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ABSTRACT

This report describes a research project designed to examine the work of four Wisconsin agencies which provide direct services to families with serious problems in parent-child interactions: (1) the Home and Community Treatment group at Mendota Mental Health Institute; (2) Family and Community Services, St. Aemilian Child Care Center, Milwaukee; (3) the Family Training Program, Institute of Human Design, Winnebago Mental Health Institute; and (4) Project OPT, Wisconsin Department of Health and Social Services, Madison. Section I provides background information on the research, including descriptions and comparisons of characteristics of the four agencies. The coding of records and data analyses are described in section II. Characteristics of the families served are presented in section III, and the use of Kegan's developmental theory in understanding families is discussed. Section IV looks at the process of intervention and compares the methods used by the four agencies, section V discusses evaluating the effectiveness of the intervention, and section VI examines whether one can account for the outcomes of intervention. The costs of services are reviewed in section VII. Section VIII provides a summary and implications. The appendix contains the Family Rating Scale, a description of the scale, and one data table. Fifty-six data tables are provided throughout the text. (NRB)

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**Wisconsin Department of Health & Social Services**
**Division of Community Services**

# FACILITATING FAMILY CHANGE:
## A Look at Four Agencies Working Intensively with Families

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by:
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May 1983

Study supported by Grant # 90-CW-628, Children's Bureau, Administration for Children, Youth and Families, Department of Health and Human Services, Washington, D.C.

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The grant was administered by the Wisconsin Department of Health and Social Services, through the Division of Community Services, and we acknowledge the assistance of the many staff members who facilitated our functioning within the state system. Through a contract with the Madison Academic Computing Center, University of Wisconsin, Madison, the data analysis was carried out.

Most of all we are indebted to the agencies that permitted us to examine their services and records. We were greatly heartened by the genuine interest each indicated in having the data analyzed and in having their work studied in an objective fashion. The staff members of each group were not only most cooperative and helpful but also most hospitable as we worked in each setting. Without their cooperation and help this study could not have been done. The staff of the Home and Community Treatment group, Mendota Mental Health Institute, included Sharon Mikkelson, Donna Morrissey, William Mello, Mary Ann Fahl, Molly Kirley, and Barbara Scholz. That of the Family Training Program, part of the Institute of Human Design, Winnebago Mental Health Institute, included Karen Reinke and Anne Rehfuss. The staff of Family and Community Services, affiliated with the St. Aemilian Child Care Center, included Don Daniels, Robert Blazich, Social Worker-Administrator, Jane Spencer and Kris Thompson who worked painstakingly in coding their records. Permission to use the data from Project OPT, much of which had been coded when that work ended, was granted by the state, as well as permission to use the records for further analysis.

The impetus to apply for this grant was largely due to the persistent encouragement of Dr. Audrey Hinger, on the DCS staff at the time, and of Mary Ann Fahl of the HCT staff. Each had recognized for years the need to examine the carefully maintained records of the HCT group and the value in a thorough analysis of the data available.

We wish to acknowledge a very special indebtedness to Lisa Lahey, a staff member of the project during its first year, and a continuing consultant during the second year. She introduced Robert Kegan's recent work on developmental theory to us; it has had a great impact on some of the ways in which we have looked at the data and have gained understanding of it. She developed the specific codes pertaining to the theory, trained other staff members, and has continued to contribute to our understanding of it. To Dr. Kegan himself we are indebted for the opportunity to meet with him when fortuitous circumstances brought him to Madison.

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# TABLE OF CONTENTS

ACKNOWLEDGEMENTS . . . . . . . . . . . . . . . . . . . . . . i

I. BACKGROUND OF THE RESEARCH . . . . . . . . . . . . . . . . 1

Introduction . . . . . . . . . . . . . . . . . . . . . . . 1
Characteristics of the Agencies Studied . . . . . . . . . . 3
    The Home and Community Treatment Group at Mendota Mental Health Institute (HCT). . . . . . . . . . . 3
    Family and Community Services, an outpatient outreach unit of St. Aemilian Child Care Center, Milwaukee (FCS) . . . . . . . . . . . . . . . . . 4
    Family Training Program, Institute of Human Design, Winnebago Mental Health Institute (FTP) . . . . . . 4
    Project OPT, Optimal Planning for Children, Department of Health and Social Services, Madison (OPT) . 5
Comparison of Agencies . . . . . . . . . . . . . . . . . . 5

II. METHODOLOGY . . . . . . . . . . . . . . . . . . . . . . . 17

Coding the Records . . . . . . . . . . . . . . . . . . . . 18
    Coding the HCT records . . . . . . . . . . . . . . . . 18
    Coding the FCS records . . . . . . . . . . . . . . . . 18
    Coding the FTP records . . . . . . . . . . . . . . . . 19
    Coding the OPT records . . . . . . . . . . . . . . . . 19
Early Analysis of Data . . . . . . . . . . . . . . . . . . 19
Construction of the Master Tape. . . . . . . . . . . . . . 19
Statistical Analysis . . . . . . . . . . . . . . . . . . . 20

III. CHARACTERISTICS OF THE FAMILIES SERVED . . . . . . . . . 21

Sources and Reasons for Referral . . . . . . . . . . . . . 21
Family Constellation and Size . . . . . . . . . . . . . . 22
Socioeconomic Indicators . . . . . . . . . . . . . . . . . 23
Other Background Data. . . . . . . . . . . . . . . . . . . 25
    Mother's background. . . . . . . . . . . . . . . . . . 25
    Prior treatment experienced by the family . . . . . . 26
Characteristics of the "Targeted Child". . . . . . . . . . 27
    Extent of problems shown by the child. . . . . . . . . 27
    School placement of the child . . . . . . . . . . . . 29
    Early development of the child . . . . . . . . . . . . 29
Were Problems of the Family Mainly Child, Adult, or Both? . . . . . . . . . . . . . . . . . . . . . . . . 31
The Use of Kegan's Developmental Theory in Understanding Families . . . . . . . . . . . . . . . . . . . . . . . 32
    The developmental level of children. . . . . . . . . . 34
    Use of developmental theory in understanding the parent. . . . . . . . . . . . . . . . . . . . . . . 35
    The environment provided the child . . . . . . . . . . 39

IV. THE PROCESS OF INTERVENTION. . . . . . . . . . . . . . . . . . . 45

A Comparison of the Methods Used by the Four Groups. . . . 45
Evidence of Defensiveness Shown by the Parents and Support Provided by the Staff during Intervention. . . 51
  Role of staff. . . . . . . . . . . . . . . . . . . . . 51
  Involvement of father. . . . . . . . . . . . . . . . . 52
Length, Intensity, and Location of Service to Families . . 52
  Length of service. . . . . . . . . . . . . . . . . . . 53
  Contacts with families . . . . . . . . . . . . . . . . 57
  Location of service. . . . . . . . . . . . . . . . . . 57
Did Treatment Continue as Long as Staff Believed It Important? . . . . . . . . . . . . . . . . . . . . . . 57
  Relationship of reasons for referral and non-completion of treatment . . . . . . . . . . . . . . 59
  Family characteristics and non-completion of treatment . . . . . . . . . . . . . . . . . . . . 59
The Goals of Treatment as Evidence of Methods Used . . . . 61
  Goals for the parents. . . . . . . . . . . . . . . . . 61
  Goals for the child. . . . . . . . . . . . . . . . . . 65

V. EVALUATING THE EFFECTIVENESS OF THE INTERVENTION . . . . . 69

Judgments of Extent of Change within the Family. . . . . . 70
  Development of parent change score . . . . . . . . . . 70
  Development of child change score . . . . . . . . . . 73
Extent to Which the Specific Goals Were Judged to Have Been Attained. . . . . . . . . . . . . . . . . . . . . 74
Use of Change Scores and Goal Outcome as Main Outcome Measures . . . . . . . . . . . . . . . . . . . . . . . 75
Changes in the Holding Environment Provided the Child and in the "Core Problems" of the Primary Parent . . . 76
  The characteristics of the holding environment and changes occurring . . . . . . . . . . . . . . . 76
  "Core problems" of the parent. . . . . . . . . . . . . 80
  To what extent are the "core problems" amenable to change? . . . . . . . . . . . . . . . . . . . . . . 82
Parents' Adult or Non-parenting Problems . . . . . . . . . 85
  Summary description of parents' problems . . . . . . . 86
  Significance of the mother's developmental level . . . 87
The Family Rating Scale. . . . . . . . . . . . . . . . . . 88
Follow-up Information. . . . . . . . . . . . . . . . . . . 90
  Status of family and child after end of intervention . 90
  Removal of children from families treated. . . . . . . 91
Observations of Interaction within the Family. . . . . . . 93

VI. CAN THE OUTCOME OF INTERVENTION BE ACCOUNTED FOR? . . . . . 97

Relationship of Characteristics of Families and Child at Time of Intake with Outcome . . . . . . . . . . . . 98
Parent and child change scores . . . . . . . . . . . . 100
Parent and child goal outcome. . . . . . . . . . . . . 102
Relationship of the Goals of Intervention with Outcome . . 106
Relationship of Parent Problems with Outcome . . . . . . . 109
Relationship of Combined Independent Variables with Outcome . . . . . . . . . . . . . . . . . . . . . 110
Inclusion of a process variable, the parent's defensiveness during intervention . . . . . . . . . 118
Inclusion of the mother's developmental level . . . . 125
Can Withdrawal from Treatment Be Predicted?. . . . . . . . 125
Summary. . . . . . . . . . . . . . . . . . . . . . . . 127

VII. THE COSTS OF SERVICES. . . . . . . . . . . . . . . . . . . 131

Comparison with Costs of Alternative Services. . . . . . . 131

VIII. SUMMARY AND IMPLICATIONS . . . . . . . . . . . . . . . . . 133

APPENDIX . . . . . . . . . . . . . . . . . . . . . . . . . . 147

Family Rating Scale. . . . . . . . . . . . . . . . . . . . 147
Description of Family Rating Scale . . . . . . . . . . . . 149
Table 1. Correlations of Parent Change Score and Child Change Score with Independent Variables for Families Served by Four Agencies and by Three (HCT, FTP, OPT) . 151

# CHAPTER I
# BACKGROUND OF THE RESEARCH

## INTRODUCTION

This research grew out of a long standing concern in the child welfare field with helping families resolve interactional problems with their own children and thereby avoid removal of the child. Too often the only available solution to such problems has been removal of the child(ren) to substitute care--either foster care or institutionalization--action that creates a host of additional problems while missing the opportunity to teach the natural parents how to cope with and interact positively with their children.

The extent of the problem is illustrated by the finding that more than half of the 395,000 children in foster family care in the United States in 1977 had been in foster care longer than two years, and as many as one-third more than four years (Shyne and Schroeder, 1978). And as the length of time in foster care increased, the contacts of the child with the principal child-caring person involved (generally a parent) decreased in frequency, indicating a diminished likelihood of return to the natural family (Shyne and Schroeder, 1978; Fanshel and Shinn, 1978). The national emphasis on Permanency Planning for children grew out of concern for these large numbers of children in foster care and awareness of the difficulties involved in returning them to the natural family once removal has occurred. However, the Oregon and Alameda studies (Pike, 1976; Stein and Gambrill, 1976) indicated that if more staff with smaller caseloads were available to work on developing permanent plans for children in foster care, more of the children would be returned to their own families than was earlier thought possible. At about the same time, a demonstration in New York state indicated that even when removal of children to foster care was already planned, this removal could be prevented if services to the families were substantially increased, primarily by reducing case loads of workers (Jones, Neuman, and Shyne, 1976). Others have also described the effectiveness of intensive services to a family in crisis because of the plans to remove an individual from the home, (Kinney et al., 1977; Haapala and Kinney, 1979) and to families having serious problems in providing adequate care for their children (Callard and Morin, 1979). Also contributing to the increased concern with the natural family and keeping it intact has been greater public and professional awareness of child abuse, with the resulting emphasis on providing services to such families so that the potential for abuse is eliminated or substantially diminished.

However, the conclusions reached in a three-year evaluation of the thirteen projects funded by the first National Demonstration Program in Child Abuse and Neglect indicated that the potential for abuse was judged significantly lessened in a larger proportion of families served by lay workers supervised by a trained worker than of those with whom professional staff worked (Cohn, 1979). One of the differences in the two kinds of services noted was that lay workers had smaller caseloads and more time to spend with clients, suggesting that this may be one of the essential requirements of effective work with dysfunctional families.

In all of these developments the interest in services to the natural family is paramount, but the questions of the kinds of services that are effective for different kinds of problems remain. Jones et al. (1981), reviewing available work in the field, found that the longer services were available and the more comprehensive the services were, the more likely treatment was to be effective. The use of contracting also appeared to be related positively to outcome although some difficulties with the use of this method were noted when protective services were provided.

Using data describing work with 52 low-income families at risk of removal of their children because of neglect (Callard and Morin 1979) concluded that the three most important features of their intervention were (1) a supportive relationship, (2) direct services, primarily to upgrade the environment in the home, and (3) modeling appropriate child care and re-education. In this report the importance of flexibility in planning and providing services is emphasized. However, if it is desirable to expand services in order to preserve families and increase the parents' potential to provide a healthy environment for their children, much more specific information is needed regarding all aspects of the work.

These needs are particularly apparent at the present time, when county departments responsible for social services frequently function primarily as "brokers", arranging for referral of clients to other service providers (psychotherapists, budget specialists, homemakers, etc.). All too often such discrete services provide only temporary relief. And when agency budgets are cut, a recent analysis of policies in one state indicates that funds to provide help to intact families are among the first to be cut, while funds supporting the removal of children to foster care are most likely to be retained (Hubbell, 1981). Doubtless these policies are at least in part continued because of greater familiarity with the foster care system, as contrasted with lesser known and less well-defined methods of working directly with families. Even in the area of family therapy, which has grown and blossomed during the last decade, there is a recognized need for research study of the entire process, including client and treatment characteristics as related to outcome measures (Lebow, 1981; Woodward et al., 1981; Gurman and Knisker, 1981).

Since several agencies in Wisconsin for a number of years have been providing direct services to families with serious problems in parent-child interaction, this research project was designed to examine their work in an attempt to gain a better understanding of their entire approach, including the kinds of problems dealt with, the methods used in the attempts to produce genuine change within the families, and the relative success of the efforts made. Each agency has recognized the need for such a study but with one exemption they have not had funds available to devote staff time to data collection or analysis. In view of increasing statewide and national interest in preserving intact families, it seems essential to examine these efforts and if possible obtain information relevant to the following questions:

> What is the evidence that these approaches are successful, that is, that they not only preserve the intact family but at the same time enable it to provide a stable and growth-enhancing environment for its children?

Are these efforts more effective with some kinds of families or some types of problems than with others?

What kind of investment of time and money is required?

## CHARACTERISTICS OF AGENCIES STUDIED

Four agencies providing direct services to dysfunctional families were selected for this study. A brief description of each follows, and a detailed comparison of the four is presented in Table 1.

### The Home and Community Treatment group at Mendota Mental Health Institute (HCT)

Originating in a small treatment institution for emotionally disturbed children, part of the larger institute, this group is the oldest of the four. They not only developed their own innovative and carefully worked out approach but also can be credited for stimulating and supporting the development of each of the other agencies included in this study as well as others in a number of counties in Wisconsin[1] and as far afield as Iowa, where Families, Inc. now serves fourteen Iowa counties (Ryan, 1979).

The HCT staff developed their basic methodology in the early 70s, after observing that significant gains made by emotionally disturbed children in the institutional setting were rarely maintained after the children returned home. This suggested that the problems lay within the family system and community rather than solely within the child and led to the development of methods of involving and working within these systems.

The principles involved in the HCT approach were initially based on social learning theory (Tharp and Wetzel, 1969): that most behavior is learned and is maintained because it brings certain dividends or rewards, that it can be changed or replaced if more socially desirable ways of obtaining these same rewards are identified and learned, and that the parent can be an effective change agent (Fahl and Morrissey, 1979; Fahl, 1980). Using the social learning paradigm, and the behavior management techniques found effective in the institutional setting, the staff continued to refine the approach during much of the 70s. The basic approach of HCT is to enable parents to examine their own and their child's behavior, have a clear idea of what is appropriate to expect of their child and what it is they can do in their interaction with the child to achieve this. The use of praise, clear direct statements, time outs, helping a child express feelings, and provision of a more stable structured environment when appropriate are some of the child management techniques included in training parents. They also use counseling methods to help parents resolve personal conflicts and non-parenting problems. Their procedures have been described in detail in a manual prepared from available materials, The Home and Community Treatment Process: Helping Families Change (1979).

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[1] It is important to note that this group has had the additional function of spending approximately one-half of its time in educational and training efforts, focused both on prevention and treatment. Using an apprenticeship approach, they have trained staff members in such agencies as mental health clinics and county departments of social services in the specific use of their methods. The Milwaukee County Department of Social Services, the largest in the state, now has five teams consisting of two or three workers each. The first team was directly trained by HCT staff. In addition, many graduate students have spent time working with HCT teams as part of a field placement or internship.

## Family and Community Services, an outpatient outreach unit of St. Aemilian Child Care Center, Milwaukee (FCS)

A private, non-profit agency, FCS works primarily with families to prevent institutionalization of children and youth who might otherwise require residential treatment, and to facilitate the transition of those returning to the community from treatment centers. It developed out of concern on the part of the institutional staff at St. Aemilian's (a residential center for emotionally disturbed boys) that the benefits of their care be maintained once the youth returned home, as well as the staff's observation of the apparent effectiveness of the HCT approach in working with families. The staff was not directly trained by the HCT but was familiar with the work of this agency.

FCS was supported in the past by a contract with the Waukesha County Mental Health Clinic, which made direct referrals or screened referrals from other sources. In 1983, the Mental Health Clinic itself began to provide the same services to families taking over the previously contracted responsibilities.

## The Family Training Program, Institute of Human Design, Winnebago Mental Health Institute (FTP)

Although technically a part of the other state Mental Health Institute in its Institute of Human Design, and begun as an outreach effort of this Institute with four staff members, FTP now functions under a direct contract with the Winnebago County Department of Social Services, which covers staff, travel, and supplies costs. Winnebago Mental Health Institute provides space, phone, and some support services. It is significant that in a time of reduced funding for human services at every level of government, Winnebago County Department of Social Services has increased the amount of their contract with FTP for 1982, paying for services to more families than previously contracted for.[2]

The original staff had a general familiarity with the HCT work at Mendota, and believed similar services were much needed in their area, but were not directly trained by the HCT group. A complete turnover in staff occurred in December 1979 but the overall emphasis on teaching parenting skills has remained the same.

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[2] Interest in the work of this group has increased within the past year in neighboring counties. In one, FTP has completed a one-year contract, and in another, FTP has concluded a contract to provide services during 1982 with a part-time staff of two. Inquiries have also been received from another county.

10

Project OPT, Wisconsin Department of Health and Social Services, Madison (OPT)

OPT, a shorthand designation for a research and demonstration project titled "Facilitating Long-term Optimal Planning for Children," was funded by the Center for Child Advocacy, Children's Bureau, ACYF, along with ten other projects, to further the effort toward Permanency Planning demonstrated in the Oregon project (Pike, 1976). Because of the inherent time limitations of the two-year grant, the decision was made to test the effectiveness of short-term intervention, limited to a period of twelve weeks after basic data had been collected through systematicinterviews with each family member and observations of family interaction. Although such a period of treatment was recognized as extremely brief, there is some documentation of the advantages of short, time-limited therapy (Butcher and Koss, 1978). Two HCT staff members trained the OPT staff which functioned in inter-disciplinary teams in all of the work with families.

There was a strong research component to the study and some of the findings have been reported (Cautley, 1979; 1980a; 1980b). However, the process data had not been analyzed, nor the systematic follow-up data, collected at six month intervals up to a maximum of 18 months following the termination of services.[3]

## COMPARISON OF AGENCIES

The main characteristics of each of these agencies are summarized in Table 1. From an examination of this information, it is clear that they differ in a number of ways. In fact, it would have been preferable to analyze each set of data as a separate unit except for the limitations imposed by the small numbers of cases.

One of the primary differences among these four agencies is the length of time they have been in existence (Table 1). HCT, clearly the oldest, also may be credited for stimulating the development of the other three. The other major difference would seem to be the relative emphasis on the behavioral approach in teaching child management methods. This is an essential aspect of the work of three groups, HCT, FTP, and OPT. FCS, on the other hand, while including child development and some of the principles of behavior change in the training provided most families, does not devote as much time or energy to training the parents in child management. This is doubtless in part due to the greater age of many of the children/youth they work with but is also related to their point of view that most families coming to them have problems that the adults first need to resolve; these are often interactional between the two members of the couple. Hence they place more emphasis on counseling parents, and traditional family therapy in some instances. The other three groups provide some counseling to parents, depending partly on the interests and skills of particular staff members involved with families. FTP, more than the others, refers families to other community resources for a variety of services.

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[3] Although OPT existed only for two years, some references to it will be in the present tense, simply to make the text less complicated to read.

The four agencies are similar in the following respects:

1. These agencies provide services only to families referred by another helping agent.[4]

2. All families are referred because of evident problems in parent-child interaction.

3. Participation of the families is completely voluntary--with one exception, in which the juvenile court judge ordered a family to participate as an alternative to the removal of the child.

4. Each uses systematic observation of family interaction in the home prior to beginning any treatment efforts, believing that far more can be learned in this way than in a similar period of time devoted to just talking with family members.

5. Each uses a formal feedback session with the family to go over the perceptions of the staff based on observations and other information gathered, and to discuss and agree on the first goals of treatment.

6. Each uses written contracts with the family, although these vary to some extent in the following ways:

   HCT currently specifies in contracts the conditions of treatment, including expectations of the family and of staff, the goals for a specific period of time, and in some cases the desired level of performance in certain specific behaviors shown by parents and/or the child.

   FTP uses highly specific contracts with 30-day goals and the objectives of treatment, often stated in terms of desired level of performance in certain specific behaviors of the parents and/or child.

   OPT used an initial contract with each client family, specifying the general expectations of the family and of staff, and permitting the collection of "baseline data," consisting of an initial interview with each family member in the presence of the others, and of at least three periods of systematic observation in the home. Additional written contracts were used with some families to describe the specific expectations regarding certain behaviors of the parent and/or child.

   FCS uses a Voluntary Participation Agreement signed by the clients early in treatment. It details expectations of the family, what they may expect of staff, and what can be expected of the referring Mental Health Board, in regard to five phases of the work: intake, assessment, goal negotiation, goal-directed intervention, and termination and after-care.

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[4] Three self-referrals were accepted out of the 167.

7. Each conducts most (HCT, FCS) or all (FTP, OPT) of its treatment in the family home, with additional contacts when needed with the school or day care center attended by the child. Working with some developmentally disabled youth, FCS also met with these individuals in a community setting in order to teach social skills and provide social experiences for the youth. HCT, in its first sessions with a family, provides didactic training in the office where the situation can be more controlled and observations for the purpose of training can be made through one-way vision screens.

8. Each emphasizes the importance of working with the entire family, although FTP is more willing than the others to work with a family even if the father refuses involvement. The involvement of the father is regarded as extremely important by the other three groups and only under exceptional circumstances is treatment likely to be continued without his participation at least part of the time. This means that much work may need to be done in the late afternoon or early evening. Flexible hours for staff are a requirement.

## Table 1
## CHARACTERISTICS OF FOUR AGENCIES PROVIDING THE DATA ANALYZED IN THIS PROJECT

| | Home and Community Treatment, Mendota Mental Health Institute, Madison | Family and Community Services, St. Aemilian Child Care Center, Milwaukee | Family Training Program, Winnebago Mental Health Institute, Winnebago | Project OPT, Wisconsin Department of Health and Social Services, Madison |
|---|---|---|---|---|
| | HCT | FCS | FTP | OPT |
| Year services began | 1969 | 1977 | 1977 | 1977 |
| Period of work described by data | 1973 through early 1982 | 1977 through August, 1981 | 1977 through August, 1981 | 1977 through September, 1978 (duration of Project) |
| Number of records available | 70[a] | 45 | 20 | 32 |
| Source of funding | Housed in state institution; personnel, travel, and other expenses paid by state; third party reimbursement when possible, and a small amount in direct payments by clients. | Contract with Waukesha Mental Health Clinic. Paid per hour of service provided each family. Charge for this hour computed to cover all personnel, travel, and other costs.[b] | Housed in state institution. Contract with County Department Social Services covers personnel, travel, clerical services, and other expenses. | Two year Federal grant (90-C-966 from ACYF) which covered all personnel, travel, office space, equipment and furnishings, and other expenses. |

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[a] Although this group began its work in 1969, a number of changes were made during the early years to refine and improve the approach used. Hence, only records of families accepted after January 1, 1973, (with two exceptions) are included in the data analyzed here.

[b] In late 1982 Waukesha Mental Health Clinic has taken over the functions of this group and is providing similar services. One staff member of the FCS group, the social worker, heads the staff at the Mental Health Clinic.

CHARACTERISTICS OF FOUR AGENCIES PROVIDING THE DATA ANALYZED IN THIS PROJECT

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| Staff | Interdisciplinary staff of six persons (social worker, psychologist, occupational therapist[c], nurse, teacher, specialist in child development). | Interdisciplinary staff staff of four (social worker administrator[c], social worker, youth care counselor, teacher). | Two since 1/1/80 (counselor and social worker-administrator[c]). Earlier staff included six individuals, mainly social workers or psychologists, four at any one time. | Interdisciplinary (social workers, psychologists, counselor, teacher, social psychologist[c]); three were part-time. |
| Source of referral | Before 1975: social agencies, schools, etc. Since 1974: various community sources, but all screened by Dane Co. Mental Health Center. | Waukesha Mental Health Clinic, from own case load and from families referred by County Department of Social Services and others. | Winnebago County Department of Social Services. | Any helping professional or agency in Dane County, mainly County Department of Social Services and school social workers. |
| Reason for referral | Generally serious problems in parent-child interaction, often evidenced in serious emotional or behavioral problems of child. | Problems in parent-child interaction, often involving a developmentally disabled child or an emotionally disturbed child. Over one-fourth to help parents maintain the gains made by the child in an institutional setting. | Before 1979: problems in parent-child interaction. After Jan., 1979: abuse or or neglect. | Problems in parent-child interaction judged to be detrimental to the healthy growth and development of the children. |

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[c] This individual is the administrator, but in each agency is actively involved in work with families.

## CHARACTERISTICS OF FOUR AGENCIES PROVIDING THE DATA ANALYZED IN THIS PROJECT

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| Criteria for acceptance | Screened and approved by Dane Mental Health Center. Since 1974: some other means of treatment must have been attempted and found ineffective. Family judged sufficiently motivated to benefit from intervention. | Judgment made that only intensive in-home intervention would be likely to produce change in the family. | Parents do not evidence severe mental illness or severe problems with alcohol or drugs. Willingness to work with program. | Family willing to sign a contract to permit initial collection of observations and initial interview. |
| Age range of children served | 3-10 on admission. | 4-16 years. | Up to age 15. | Up to age 12. |
| Is there an identified patient (IP) in the family? | Because of requirement of mental health system, an IP always had to be identified but in some instances all of the children in the family were approximately equal in problems presented. | Yes, because of requirements of mental health system and the particular needs of the children referred, although interaction with siblings received attention. | Generally one child was perceived as the focus of treatment because of severity of problems, but all children were included in the treatment plans. | Generally, although in a few families all of the children presented equally difficult problems. |
| Did staff generally work in teams of two? | Yes; occasional exception was in work with single mothers with one young child. | Most of time spent working individually with IP or family, but team of two generally involved with a family and may meet with them once a week. | At times, but generally as individuals. | Yes; occasional exception was in work with a single mother with one young child. |

CHARACTERISTICS OF FOUR AGENCIES PROVIDING THE DATA ANALYZED IN THIS PROJECT

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| Availability of consultants. | Child psychiatrist at Mendota Mental Health Institute during early years. Since 1976 a child psychiatrist devotes four hours a week, generally interviewing the parents prior to and at the end of treatment, and observing and interacting with the child in a playroom setting at both times. | Meets with a consulting psychologist every three weeks to discuss cases. | Children's Consultation Service of Winnebago Mental Health Institute available and utilized as needed. | Two members of the HCT staff trained OPT staff in the use of their methods and met three hours each week with the entire OPT staff to review cases and provide consultation. |
| Locus of work with clients. | Early didactic training provided in office setting; most of other contacts with family in home; intensive work in schools in a few cases. | None in office. Individual work with IP in home, or in community setting to teach social skills. Work with family in home. | None in office. Work in home. Some consultation with teachers. | None in office. Work in home; some observations and consultation with teachers in schools. |
| Methods Used | | | | |
| 1. Systematic observation of family interaction | Always used, generally at least three periods of one and one-half hours in home, also of child in school if indicated, generally of family interaction during in-office training, and with some families during treatment to assess progress. | Always used, generally in home, typically three times. | Always used, seven to eleven times of an hour each in the home. | Always used, generally three times averaging one and one-half hours each in the home. For research purposes observations of the same length were conducted at the end of treatment to evaluate progress. |

# CHARACTERISTICS OF FOUR AGENCIES PROVIDING THE DATA ANALYZED IN THIS PROJECT

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| 2. Contracts | Almost always, but number of contracts and degree of detail varied over the years and with the perceived needs of the family; generally include obligations of family and of staff to keep appointments on time or to notify the other party. Some may be very detailed. | In first two years used specific detailed contracts including Goal Attainment Scaling. Generally used fewer contracts with family in later years. | Typically have agreements called 30-day goals and objectives" (which may last a considerably longer period of time), which are reviewed with family and replaced with another contract. | Always used at beginning to permit observations and initial interview. Occasionally used during treatment to specify conditions of treatment |
| 3. Formal feedback session to present goals of work. | Used routinely. | Used when deemed appropriate. | Used routinely. | Used routinely. |
| 4. Specific behavioral goals for parents. | Almost always stated. | Only when deemed appropriate. | Almost always. | Almost always. |
| 5. Specific behavioral goals for child. | Generally. | Only when deemed appropriate | When appropriate. | In a few cases. |

## CHARACTERISTICS OF FOUR AGENCIES PROVIDING THE DATA ANALYZED IN THIS PROJECT

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| 6. Didactic training. | Very systematically. | Mainly through parent training provided in groups if possible but otherwise individually. | Generally. | Generally. |
| 7. To what extent is there a focus on specific behavioral goals? | Trend towards more specific statement of behavioral goals for both parents and child stated both as long term and short term goals, although there is often considerable effort devoted to other goals of treatment. | Early in project, Goal Attainment Scaling was used, but has been dropped. Less emphasis on behavioral goals, more on personality problems of parents and the effect of these on the child. | Traditionally have required a statement of goals and objectives for each 30-day period of training, although often the 30-day period is extended for double or triple this length of time when additional goals added as needed. | Specific goals of treatment, in most cases primarily behavioral, were agreed upon during the first feedback session, reviewed after the first eight weeks of treatment, assessed and possibly changed at that time. |
| 8. Is treatment of non-parenting problems of parent provided? | Yes, through counseling and, by some staff, through methods of traditional family therapy. | Yes, counseling parents has been of major importance in treatment provided in recent years. | Yes, to some extent, mainly as they affect parenting. | Yes, when conflicts or problems were uncovered, staff worked to resolve these through counseling, particularly by some staff members. |
| 9. Is individual treatment of IP provided? | In a few instances when needed, play therapy is used. | Social skills training given much emphasis with the developmentally disabled in particular. | Provided in some cases during early years; rarely since January 1980. | No; entire focus was on parent-child interaction. |

CHARACTERISTICS OF FOUR AGENCIES PROVIDING THE DATA ANALYZED IN THIS PROJECT

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| Theoretical point of view of agency. | Primarily based on social learning principles and analysis of antecedents and consequences of the problem behaviors of the child, used as basis for modifying the behavior. Also a systems approach, in which attempt is made through understanding the dynamics of the family system to determine where a change needs to be introduced. Counseling of parent(s) regarding personal problems and in recent years, family therapy by some staff members. | Primarily Minuchin's structured family therapy, to understand what needs to be changed in the family structure. Frequently perceived as less involvement from an over-involved mother and under-involved father or in terms of other problems of parent relationships affecting the child. Principles of social learning also used. | Primarily social learning principles, teaching the parents appropriate child management methods as well as encouraging them to think in terms of rewards for desirable behavior in their children and in themselves. | Similar to that of HCT, since training was provided by two HCT staff members. In addition, some emphasis by several staff members on family therapy. |

CHARACTERISTICS OF FOUR AGENCIES PROVIDING THE DATA ANALYZED IN THIS PROJECT

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| How was the end of treatment determined? | When staff and client agreed that the treatment goals had been generally attained and family felt able to continue on its own, or, in some cases by withdrawal of the family from treatment or by other reasons such as family's moving away. | When staff and client agreed that the treatment goals had been generally attained and family felt able to continue on its own, or, in some cases, by withdrawal of the family from treatment or by other reasons such as family moving away. In a few cases treatment terminated by staff because of apparent lack of motivation in family to make any change. | When family felt goals had been met and parents were able to effectively control children's behavior; when staff judged that family was no longer likely to abuse or neglect their child/ren, although in some cases it was clear that the family continued to have other problems. | Determined primarily by the nature of this project in which, because of its short term grant, treatment was limited to a maximum of 12 weeks with a family. Some families withdrew because they did not want to continue in treatment. |
| Are referrals to other treatment resources made during treatment? | No referrals are made to other resources during treatment except in rare instances. If a family member is involved with another resource at the time of acceptance this may continue or in some cases the team meets with the other resource and agrees as to the division of responsibility or the termination of one of the efforts. | Generally not. | May be made to any appropriate community agency or service center as alcoholism services, marriage or personal counseling, battered spouse centers, etc. Also made for psychiatric or psychological evaluation or treatment if indicated. | Rarely made, and in those few cases generally at the end of treatment to the Division of Vocational Rehabilitation and to Consumer Credit Counseling. Several clients urged to seek psychotherapy. |

CHARACTERISTICS OF FOUR AGENCIES PROVIDING THE DATA ANALYZED IN THIS PROJECT

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| Kinds of records available. | Detailed records describing every contact with a family or on behalf of the family, but because of the "open records law," information pertaining to the parent's personal problems may be omitted from the record. Initial and final summary contain good review of entire case and progress perceived by staff. | Most records not open to research staff because of confidentiality. Signed permission obtained from families for release of records used in checking and revising the code to be used. Typically consist of referral information and staff notes of individual contacts and summaries prepared for mental health clinic periodically. | Generally a social history describing both parents and their background and status of the family, 30-day training reviews, client program reports, along with handwritten notes of staff's contacts with family, details of 30-day goals and objectives, observation summary including behaviors observed and statistical breakdown, and final summary prepared for Winnebago County Department of Social Services. | Initial tape recorded and transcribed interview with each member of the family, providing information about background of both parents and their perception of the problems, detailed descriptions of each contact with family (except for two families), and evaluative questionnaires completed by team members after first 8 weeks of treatment and at the end of treatment. |
| Coding of records performed by | Research project staff. | FCS staff members, after training by research project staff and with one project staff member present for consultation. | Research project staff. | Partially completed at end of project by OPT staff not involved in work with families; otherwise carried out by research staff. |

# CHAPTER II
# METHODOLOGY

With such varied material -- in terms of the kinds of families worked with and the records kept by agencies -- developing a detailed plan for analyzing the data proved to be a major challenge. Even the development of codes depends upon what one is looking for, or believes is important to look for, in the records. It also is dependent, of course, upon the kinds of information available, but since the staff first began work on the HCT records, which were very detailed and included a typed description of every contact with a family, there was a great abundance of information available that could have been handled in a variety of ways. We were guided, first of all, by the specific objectives of the research.

Stated briefly, these were to obtain as clear an understanding as possible of (a) the characteristics of the families, including the apparent problems bringing them to treatment, (b) the kinds of intervention used, including the time and staff effort required, and (c) the relative impact or effectiveness of the intervention on the problems.

One question we attempted to address is what information is useful to either the practitioner or researcher or both, in terms of understanding families and what the relative effectiveness of the intervention means for each family. In recognition of the importance of individualizing the process of what is happening in the treatment process, an attempt was made to individualize goals and problems for each family in the coding and code outcome only in relation to goals that were relevant for a particular family in order to determine changes in relation to their own need for change.

The goal of this research is explorative and descriptive, not testing of hypotheses, focused on the relationships between the information available in the records about families, service methods, and outcome.

This should not be considered an experimental or quasi-experimental study in which the outcomes achieved by the various agencies are compared. Agency comparisons are made in terms of client population characteristics and service methods. The fact that the populations varied means there is a broader basis for the findings. However, in looking at outcome, the scores within each agency were standardized and then combined. There were several reasons for this; one was that the agencies all used similar methods in working with families. Methods and goals often varied as much within a particular agency as between them. Further, findings describing the kinds of families helped by this type of service approach would be more useful than findings comparing agencies.

In all research attempting to code information on families, service provision and outcome, there are certain problems that are inevitable (Kadushin, 1982). One problem is that the information used to determine family variables, treatment, and outcome is provided by the case workers; however, we have made an attempt to alleviate this problem somewhat with the use of independent researchers who read and coded case records of three of the agencies for family characteristics, problems, treatment goals and made their own determination of outcome. These records had not been kept with the idea that any type of research or independent evaluation would be made. The researcher's judgment of outcome was highly correlated with the agency staff judgment. While it is true that their judgments were based on the same information, they did not always agree. The outcome ratings of the researcher were used in the analysis.

Another criticism of this type of research is that the clients were not directly observed or contacted for their measurement of outcome. This, in fact, was done in one of the agencies (OPT) where it was found that client ratings of the services to them were often of little relation to improvements or lack of them as staff saw them.

## CODING THE RECORDS

### Coding the HCT Records

The research staff began work first with the HCT records as they were most accessible and also the most detailed. The first codes were developed, tried out by several staff members on the same records, sources of confusion discovered and definitions sharpened and refined. This process actually continued for about two and one-half months; even after that time some modifications were made that required returning to the earlier records to check them for accuracy. In addition to the usual demographic data describing each family, there were other background characteristics that seemed relevant to this particular study. One pertained to the background of the mother. Reliability was carefully checked to make sure that there was at least 80 percent agreement in the coding. When this was not attained in a few instances, the codes were combined (e.g., a five-point scale reduced to a three-point scale) prior to any analysis so that they would meet this requirement.

Before the coding of the HCT data was completed, contacts were made with the other agencies and their materials reviewed and discussed with them. The plan was, of course, to apply the same codes to the data from all four agencies. This conflicted somewhat with the goal also of reflecting as clearly as possible the particular approaches of each agency. For this latter reason, some codes were added for the other sets of data that had not seemed important for the HCT data. In several instances, this also meant going back over the HCT records to add certain details.

### Coding the FCS Records.

Because of the confidentiality of FCS records, signed permission had to be obtained from the clients in order to permit the research staff to review the records. This was possible for the records of only seven families; these were used primarily to check the applicability of the code. Two members of the project staff also met for a number of lengthy sessions with the two members of the FCS staff who agreed to code the remaining FCS records under a subcontract with the project. Training sessions were held with them and one member of the project staff was present and available to answer questions regarding the interpretation and/or application of certain codes during most of the periods devoted to coding the records. It is to be noted that having coding done by staff members who have worked with the families is a very different matter from having an independent research staff review and code records. Memory as well as the written record can obviously play a part in coding. There was no evidence that the FCS staff tended to over estimate the value of their work with clients; in fact, the data suggest that they were very modest in their assessment of their work and evaluation of their effectiveness.

### Coding the FTP Records

Two research staff members first reviewed a number of the FTP records, all of which were made available for research analysis, to see whether the codes developed for the HCT records would be applicable. Following that, one researcher carried out almost all of the coding of the FTP records, checking reliability by recording a record at a later time and comparing the two sets of judgments.

### Coding the OPT Records

Much of the information from project OPT had been coded at the end of that project, mainly by a staff member who had not been involved in direct work with any of the families. However, there were a number of areas that had not been covered, and none of the coding involving the application of developmental theory had been completed. These records were analyzed by one research staff member who showed the highest reliability in applying Kegan's theory.

## EARLY ANALYSIS OF DATA

Once the data were coded and transferred to punched cards, they were then examined for meaningless codes and obvious errors, which were corrected, and then transferred to tape.

A great deal of analysis was completed on each set of data before an attempt was made to combine the four sets. Reasons for this were primarily to understand the relationship within each data set as we were aware during the coding process of some of the ways in which the four agencies differed substantially. It would have been preferable to do the complete analysis of data separately for each agency, but the limitations imposed by the small numbers of cases made this impractical. Findings based on larger numbers are much more likely to be stable.

## CONSTRUCTION OF THE MASTER TAPE

The advantages of being able to describe 167 families rather than the smaller number of cases studied within each of these four groups were great. Consequently, the data were combined on one master tape. This required a long series of steps because each of the codes had been arranged in somewhat different order to facilitate efficient coding of the records of each agency. In some instances, the codes had been modified somewhat to make them easier to use for a particular agency; discrepancies such as these were generally resolved by combining categories into broader categories. Once the master tape was created, it was possible to do analyses of all of the agencies together, or singly, or in any combination. Obviously, not all of the data were combined on the master tape as a number of the codes pertained only to the data from one agency. In addition, we had found through the preliminary analysis that certain data appeared relatively unimportant, unrelated either to problems presented, characteristics of the family served, or outcome of treatment. And because we had too much information to use very efficiently, it seemed reasonable to eliminate the information that appeared not to contribute to understanding the training provided.

## STATISTICAL ANALYSIS

The entire analysis has been done using the Statistical Package for the Social Sciences (Nie _et al._, 1975) and the updated version of the same package (Hull and Nie, 1981), which are available at the Madison Academic Computing Center associated with the University of Wisconsin-Madison. After the frequency counts of all of the material coded had been completed, the data were examined for relationships, using cross tabulation and chi-square, analysis of variance, correlational analysis (using Spearman product-moment correlation) and regression analysis.

### Missing data

In a study such as this, dependent upon records kept for purposes other than research, there is certain to be missing data, that is, information on certain dimensions that is simply not available in the records, or ratings that cannot be made by the coder because there is not sufficient evidence to permit a rating. Data on some variables is missing in some instances for an entire agency.

We have not attempted to replace missing data with mean scores as it seemed more reasonable to omit it from the calculations. Fortunately the computer programs available include provisions for handling missing data. The one generally used would omit a case in a correlation, for example, if information was missing on one (or both) of the two variables being correlated, but would include the case for other correlations if data for the two variables was available. The number of cases used in various analyses will be presented along with the findings. When a regression analysis is performed and scores on a variable for an entire agency are missing, that agency is not included in the analysis. If the missing data on a variable is a relatively small percentage of the total group, a case is only considered missing in calculations involving that particular variable. Great care must be taken in interpreting analyses which use this method of handling missing data.

# CHAPTER III
# CHARACTERISTICS OF THE FAMILIES SERVED

## SOURCES AND REASONS FOR REFERRALS

Except for FTP, which receives all of its referrals from the County Department of Social Services with which it is under contract, a variety of sources have made referrals to various agencies (Table 2). Although nearly two-thirds of those made to OPT were also from the County Department of Social Services, the largest concentration of referrals to both HCT and FCS was from school personnel. Aside from this, the other two main sources for FCS were the County Department of Social Services and referral for aftercare with 27 percent of the families referred following the youth's return from a treatment institution. Sources for HCT also included the County Department of Social Services, private therapists, and a variety of others including a visiting nurse, physicians, and a private social agency.

There also are marked differences among the agencies in the reasons for referral (Table 2). For HCT the primary reasons are either the parents' difficulties in managing the child or the child's behavior in school. From one point of view, both of these might be perceived as implied criticism of the parent; this detail will be checked to see whether there are any outcome differences related to the reasons given for referral. In the case of FTP families, the implied criticism is even more evident, with emphasis not only on the parents' difficulty in managing the child for slightly over one-third of the families, but for 45 percent, the reason given is alleged abuse of the child and for another 10 percent it is alleged neglect. For the OPT families more referrals were made because of behavioral problems of the child in the home. Although such problems are very likely due to interaction with the parents, the referral would seem somewhat less threatening to the parents when the emphasis is placed on difficulties presented by the child. The most frequent reason for referral of FCS families was in regard to the aftercare cases, that is to preserve the gains made during institutional care of the child. There was relatively equal emphasis on the parents' difficulty in managing the child and on the behavioral problems of the child in the home. Reference to the child's behavior in school could well be combined with evidence of differences between the parents and school regarding the child, which also implies that the school felt critical of some aspects of the parenting.

The reasons for referral will be of use in examining the relative outcome of intervention with families referred for various reasons.

## Table 2

### Information Regarding Referral of Families

| | Agencies | | | | |
|---|---|---|---|---|---|
| Source of Referral | HCT | FCS | FTP | OPT | TOTAL |
| County Department of Social Services | 14% | 20% | 100% | 56% | 34% |
| School personnel | 49 | 40 | --- | 16 | 34 |
| County Mental Health Center | 9 | 16 | --- | 6 | 9 |
| Treatment institution for aftercare | -- | 22 | --- | -- | 6 |
| Private psychiatrist or psychologist | 11 | -- | --- | -- | 5 |
| Self referral | 6 | 2 | --- | 6 | 4 |
| Other | 11 | -- | --- | 16 | 8 |
| | 100% | 100% | 100% | 100% | 100% |
| Reasons for Referral of Families | | | | | |
| Parent(s)' difficulty in managing child (emphasis on parent(s)' lack of skill) | 37% | 18% | 35% | 25% | 29% |
| Behavioral problems of child in the home | 15 | 18 | 10 | 34 | 19 |
| Child's behavior in school | 36 | 22 | -- | 16 | 24 |
| Differences between parent(s) and school regarding child | 1 | 11 | -- | -- | 4 |
| Difficulties or concerns associated with child's developmental delay | 6 | 4 | -- | 6 | 5 |
| Alleged possible abuse of child | 3 | -- | 45 | 13 | 9 |
| Alleged neglect of child | 1 | -- | 10 | 3 | 2 |
| Plan to return child from foster care or possibility of this | 1 | -- | -- | 3 | 1 |
| To preserve gains made during institutional care | -- | 27 | -- | -- | 7 |
| | 100% | 100% | 100% | 100% | 100% |
| Number of cases | 70 | 45 | 20 | 32 | 167 |

## FAMILY CONSTELLATION AND SIZE

There are notable differences among the agencies in the parent figures present during treatment (Table 3). HCT and FCS each had a larger proportion of biological parents present in the families than the other two agencies. However, the only significant difference (.01 level) is found when the homes with two parents or parent figures present are contrasted with homes with a single parent or a single mother with a live-in mate. In this comparison the OPT families include significantly more single parents than the FCS families.

The number of children in the families worked with by each of these agencies shows considerable variation, with FCS families having an average of 3.1 children and being significantly larger than OPT families, which were the smallest (Table 3). Somewhat over one-fourth of OPT and HCT families had only one child, whereas this was the case for only 10 percent of the FTP families and 7 percent of the FCS families.

When the presence of a half-sibling or a step-sibling in the family was examined, we found that this occurred less frequently in the HCT families than in the other three groups and was most frequent among the FTP families. In 45 percent of the families in this group, there was at least one half or step-sibling in the family group, whereas this was the case for only 23 percent of the HCT families. In one sense this provides an indication of the disruption experienced by the children.

## SOCIOECONOMIC INDICATORS

The characteristics of the age, educational attainment, and employment status of each parent were examined. It is perhaps not surprising that the mothers in the FCS families were significantly older than those in either the HCT or OPT group as they had substantially more children than those other families (Table 3). Their average age was 35.9 years, whereas the average age for HCT mothers was 30.5 years, while the OPT mothers were the youngest of all having an average age of 29.1 years. The father's age was correlated highly with that of the mothers. Because of the absence of fathers in one-third of the homes, the mother's age has been used as the primary indicator. Although there are somewhat more mothers with at least some college training in the HCT and FCS families, there is no significant difference in the educational level of the mothers. However, when the father's educational level is considered, there are significant differences, with fathers in both the HCT and FCS group showing a significantly higher level of education than those in the FTP families. The degree of missing information in educational attainment and the absence of the father figure in 32 percent of all families, however, should be noted.

Considerable effort was made to code information about the parents' employment status. Although there is considerable variation among the groups in this respect, there are no significant differences (Table 3). More of the HCT mothers are employed full-time than those in any other groups, while two-thirds of the OPT mothers are not gainfully employed. Somewhat fewer than half the HCT and FTP mothers are not employed. Similar information was obtained about the father's employment, but there is such a large amount of missing data regarding the fathers in every group except FCS that it seems meaningless to report this detail.

Earned income information was not available for OPT families, but when the families in the other three groups were compared, it was clear that FCS families have significantly higher income per month than FTP or HCT families. In terms of non-earned income per month, FTP families received significantly more than FCS families. This is consistent with the data on employment status of the fathers in FCS, 78 percent of whom are employed full-time.

Table 3

## Characteristics of Families Served by Four Agencies

| | Agencies | | | | |
|---|---|---|---|---|---|
| | HCT | FCS | FTP | OPT | TOTAL |
| Parent figures present during treatment | | | | | |
| Both biological parents | 39% | 40% | 25% | 22% | 34% |
| One biological parent and step-parent | 10 | 16 | 15 | 9 | 12 |
| Two parents: adoptive, foster, or relative | 3 | 13 | -- | 3 | 6 |
| Single mother with live-in mate | 12 | 7 | 15 | 19 | 12 |
| Single mother | 33 | 22 | 35 | 44 | 32 |
| Single father | 3 | 2 | 10 | 3 | 4 |
| | 100% | 100% | 100% | 100% | 100% |
| Number of children in families | | | | | |
| One | 27% | 7% | 10% | 28% | 20% |
| Two | 46 | 33 | 20 | 38 | 38 |
| Three | 17 | 29 | 35 | 28 | 25 |
| Four | 6 | 11 | 20 | 3 | 8 |
| Five | 3 | 16 | 15 | 3 | 7 |
| Six | -- | 2 | -- | -- | 1 |
| Seven | 1 | 2 | -- | -- | 1 |
| | 100% | 100% | 100% | 100% | 100% |
| Is any child in the family group a half-sibling or step-sibling of another? | | | | | |
| Yes, one or more present | 23% | 38% | 45% | 34% | 32% |
| No | 77% | 62% | 55% | 66% | 68% |
| Age of mother | | | | | |
| 19 years | -- | -- | -- | 3% | 1% |
| 20-24 years | 12% | 4% | 5% | 19 | 10 |
| 25-29 years | 41 | 13 | 15 | 31 | 28 |
| 30-34 years | 27 | 20 | 15 | 38 | 26 |
| 35-39 years | 9 | 27 | 40 | 6 | 17 |
| 40-44 years | 10 | 16 | -- | 3 | 9 |
| 45-49 years | 1 | 11 | -- | -- | 4 |
| No information | -- | 9 | 25 | -- | 5 |
| | 100% | 100% | 100% | 100% | 100% |
| Average age of mother | 30.5 | 35.9 | 32.4 | 29.1 | |
| Number of cases | 70 | 45 | 20 | 32 | 167 |

Table 3 (concluded)

| | Agencies | | | | |
|---|---|---|---|---|---|
| | HCT | FCS | FTP | OPT | TOTAL |
| Mother's educational attainment | | | | | |
| 9th grade or less | 3% | 11% | 10% | 13% | 7% |
| 10th or 11th or 12th grade | 19 | 16 | 20 | 28 | 20 |
| High school graduate or GED degree | 51 | 47 | 35 | 44 | 47 |
| Some college | 19 | 18 | -- | 9 | 14 |
| College graduate | 7 | 1 | -- | 6 | 5 |
| Technical, special education post graduate in progress | 1 | -- | -- | -- | 1 |
| No information | -- | 7 | 35 | -- | 6 |
| | 100% | 100% | 100% | 100% | 100% |
| Father's educational attainment | | | | | |
| 9th grade or less | 4% | 2% | 15% | 3% | 5% |
| 10th or 11th grade | 9 | 13 | 5 | 19 | 11 |
| High school graduate or GED equivalent | 26 | 38 | 20 | 19 | 27 |
| Some college or further training | 14 | 16 | -- | 6 | 11 |
| College graduate | 7 | 2 | -- | 6 | 5 |
| Post graduate(studies/degree received) | 4 | 11 | -- | -- | 5 |
| No information or no father figure present | 36 | 18 | 60 | 47 | 36 |
| | 100% | 100% | 100% | 100% | 100% |
| Is mother employed? | | | | | |
| Yes, full-time | 36% | 18% | 20% | 25% | 27% |
| Yes, part-time | 16 | 22 | 20 | 9 | 17 |
| No | 48 | 58 | 40 | 66 | 53 |
| No information | -- | 2 | 20 | -- | 3 |
| | 100% | 100% | 100% | 100% | 100% |

## OTHER BACKGROUND DATA

In addition to the usual demographic data describing each family, there were other background characteristics that seemed relevant to this particular study. One pertained to the background of the mother.

### Mother's background

Two suggestive findings from the earlier analysis on the OPT data pertained to the mother's background. One was an indication that mothers whose first child had been born when they were under 20 years of age were less likely to respond to the intervention than mothers who had been over 20 when their first child was born. Since in the data for all of these agencies the mother's age and the ages of her children had been coded, it was possible to identify all of the mothers who had been under 20 when their first child was born.

Another kind of evidence from the OPT data was that the quality of the mother's own rearing seemed to be related to the effectiveness of this short term intervention. It was possible to code this only for the HCT data in addition to the OPT data, however, and even in some HCT records there was very little information given about the mother's growing up experiences because of the open records law. Four different kinds of information were coded when available in the HCT records:

-- whether the mother's childhood had been generally happy or unhappy

-- her current relationship with her own mother-whether problematic or good,

-- evidence of her having experienced rejection from a significant child-caring person during her growing up years,

-- whether she had had treatment for emotional problems.

Since there was considerable missing data on each of these items, they were averaged to yield one code on a three point scale. Somewhat different kinds of information were available from the earlier OPT data, including a general assessment made by the mother of her own childhood, and information as to whether she had received praise and affection from each of her parents. However, it seemed feasible to combine these kinds of information in a three-point scale ranging from evidence of a reasonably satisfactory childhood to a very unhappy childhood. This variable is called Mother's childhood.

## Prior treatment experienced by the family

Information regarding the prior treatment experienced by the family was coded for all except the OPT families, for whom it was not available. Although a great deal of detail was coded, including the kind of agency or professional providing the treatment, the members of the family treated, and the length of treatment, this information was summarized in a five point scale, defined as follows:

1. Family experienced prior treatment for a significant period of time (6 months or more) with at least two different agencies or sources.

2. Family experienced prior treatment for a significant period of time with one agency or source.

3. Family experienced treatment for a short period of time (2 months through 5 months) with two or more agencies or sources.

4. Family experienced treatment for a short period of time with one agency or source.

5. Family experienced contacts lasting no more than one month or less with one source, generally for diagnostic study.

This variable is called Prior treatment.

Codes were also developed to describe whether the parents and child were treated together, whether the emphasis was primarily on treatment of the parents or whether the identified child was primarily the individual seen. However, in general this information was not given in sufficient detail to code for a large proportion of the families and, consequently, has not been used in the analysis of the total group of families.

## CHARACTERISTICS OF THE "TARGETED CHILD"

Because of the requirements of the mental health system that one member of a family referred for treatment must be identified as "the patient," such a child was always named for the HCT and FCS families although in some instances, it was clear that all of the children in the family presented problems for the parents. In most of the FTP families as well as in a substantial majority of the OPT families it was also possible to identify the "targeted child," although in some families it was clear that no child had been identified as presenting more of a problem than the others. In these cases, the age of the oldest child in the family group was coded so that the ages of the children in each of the families could be compared.

It is clear that there are substantial differences among the groups in the child's age, with the "targeted children" in the FCS families being significantly older than those in each of the other three groups (Table 4). The "targeted children" in the FTP families were significantly older than those in the OPT families, who had younger parents and younger children. The contrast of the FCS families with the others shows that 60 percent of the "targeted children" were 11 years or older, with the oldest being 17 years of age. Working with parents who are having problems with an older child/youth undoubtedly is a different matter than working with parents of a younger child. FTP families, on the other hand, showed the greatest range in age, from 2 year olds through a 16 year old.

The "targeted child" in all of the groups was far more likely to be a male than a female, although there were somewhat more females in the FTP and OPT groups than in the other two (Table 4). These differences are not significant.

### Extent of problems shown by the children

It also seemed important to describe in some way the extent of the problems faced by the parents in coping with their child, regardless of whether the problems seemed to stem from the family's interaction with the child, or were intrinsic to the child. Since only one agency had used any behavior rating scale, there were no objective data available for this purpose.[1]

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[1] FCS had asked each parent to describe their child on the Devereux Rating Scale but because of the ages of the children, 25 were rated on the Child Scale, and 10 on the Adolescent Scale. The ratings were primarily used by the staff to identify problems areas of the individual although it was initially hoped by the agency that ratings could be obtained at the beginning and end of treatment in order to provide an indication of progress. Although we spent considerable time working with these ratings, they did not seem particularly useful even in comparing children/youth within this one agency. This score does not purport to be a complete description of behavior but only covers selected dimensions.

However, both HCT and FCS records contained descriptions of the kinds of problems evidenced by the child at the time of referral. These were categorized in the following areas:

- -- socialization, primarily interaction with others
- -- conduct, primarily undesirable behavior
- -- emotional expression or development
- -- cognitive functioning, primarily in school
- -- communication skills
- -- motor development
- -- physical problems, primarily the presence of a physical handicap but also including health problems
- -- activities of daily living, primarily self-help skills
- -- child's self concept, primarily in terms of self confidence or feelings about self

The frequency with which problems in each of the areas were mentioned by parents, school, referring agency, and observed by staff, was coded for each of these areas. A total of the references to problems in all areas was also created. However, it became evident that a child presenting very difficult behavior problems, which might be coded simply in the "conduct" area, could be more difficult to handle than a developmentally delayed child with problems in many different areas. We began to question the validity of this coding as an indication of the severity of the problems presented by the child. For this reason we developed a rating based on the following question:

> "How difficult would this child be for an average family to cope with?"

The scale positions were the following:

1. Difficult
2. Quite difficult
3. Very difficult
4. Extremely difficult

We were aware that such a rating cannot be separated from a consideration of age, as a younger child in general would be easier to cope with than an older child showing the same kinds of behavior. Although it is evident that this rating is biased in terms of acting-out behavior, the fact that this relatively subjective rating was made by the same coder for data from HCT, FTP, and OPT increases our confidence in it as a means of comparing the children in this study. The FCS ratings on the same variable were made by their staff.

When the rating of the Degree of difficulty evidenced by the "targeted child" is examined, it is evident that the children in the FTP families were considered the most difficult, with 75 percent of them being rated as very or extremely difficult (Table 4). They differ significantly in this respect from those in the HCT and OPT families. One-fourth of the "targeted children" in the OPT families were given the lowest rating of difficulty.

These also were the youngest children. Only one child under the age of 7 in the OPT group was rated as extremely difficult; he was a very coercive 4 year old who controlled his mother's and step-father's behavior quite completely.

Another code was developed to identify children who had a handicapping physical problem of some kind. It was called Handicap. Included in this was evidence of mental retardation, serious learning disability, childhood psychosis, suspected or diagnosed neurological problem, or serious growth delay. It is clear that the FCS families differed significantly from those in the other three groups in that two-thirds of the FCS families had children with such problems, whereas fewer than one-third of the HCT families and fewer than one-fifth of the FTP or OPT families had children with such handicaps (Table 4).

The occurrence of Handicap was unrelated to age in any of the groups. However, it was significantly correlated with the Degree of difficulty shown by the children at a modest level of .218 for HCT, FTP, and OPT, but more highly with a correlation of .419 for FCS. This rating of Degree of difficulty suggests that behavior problems were fairly highly related to handicaps for the FCS targeted child/youth but not substantially related to the other three groups. This is undoubtedly partly due to the lower occurrence of such handicaps for the other three groups.

## School placement of children

Information regarding the school placement of the children at the time of admission also suggests considerable differences between those in the FCS families and those in the other three groups (Table 4). From 30 to 45 percent of the children in the FTP, OPT, and HCT families were in a regular classroom at a level appropriate for their age, whereas this was the case for only 16 percent of the children/youth in the FCS families. Sixty-six percent of the children/youth in the FCS families were in special classrooms at the time their families were accepted for treatment. Most of the children not in school were very young children who were not even in a nursery school setting.

## Early development of child

Information regarding the developmental history of most of the children in the HCT and FCS families was also available. The actual age at which the child sat up, walked without help, used single words, and combined words was recorded in the HCT records, while the FCS records indicated more generally whether the child was at the average level in motor and speech development, or above average, or below average. This information has been summarized in a way to permit combining data from the two agencies on a three-point scale indicating accelerated development, average development, and below average development.

## Table 4

### Characteristics of the Children

| | Agencies | | | | |
|---|---|---|---|---|---|
| | HCT | FCS | FTP | OPT | TOTAL |
| Age of "targeted child" in family or, if none, of older/oldest child | | | | | |
| 2 years | -- | -- | 10% | 19% | 5% |
| 3-4 years | 16% | 2% | 10 | 20 | 12 |
| 5-6 years | 39 | 14 | 15 | 25 | 26 |
| 7-8 years | 24 | 10 | 15 | 15 | 18 |
| 9-10 years | 20 | 14 | 20 | 9 | 16 |
| 11-13 years | 1 | 31 | 20 | 9 | 13 |
| 14-17 years | -- | 29 | 10 | 1 | 10 |
| | 100% | 100% | 100% | 100% | 100% |
| Average age of child | 6.57 | 11.07 | 8.40 | 6.03 | |
| Sex of "targeted child" in family or, if none, of older/oldest child | | | | | |
| Male | 81% | 89% | 70% | 66% | 79% |
| Female | 19 | 11 | 30 | 34 | 21 |
| | 100% | 100% | 100% | 100% | 100% |
| Is child handicapped in some way? | | | | | |
| Yes | 30% | 67% | 20% | 16% | 36% |
| No | 70 | 33 | 80 | 84 | 64 |
| | 100% | 100% | 100% | 100% | 100% |
| Relative degree of difficulty presented by the child | | | | | |
| Difficult | 13% | 16% | 5% | 25% | 15% |
| Quite difficult | 47 | 29 | 20 | 34 | 39 |
| Very difficult | 23 | 26 | 35 | 22 | 25 |
| Extremely difficult | 17 | 29 | 40 | 19 | 21 |
| | 100% | 100% | 100% | 100% | 100% |
| School placement of the child at the time of admission | | | | | |
| Regular classroom at level appropriate for child of this age | 45% | 16% | 30% | 40% | 34% |
| Regular classroom with part-time supplemental help or at level one or two years below that appropriate for child of this age | 17 | 18 | -- | 13 | 14 |
| DD, BD, ED, LD or other special classroom including special pre-school class | 34 | 66 | 20 | 22 | 39 |
| Not in school | 4 | -- | 25 | 25 | 9 |
| No information | -- | -- | 25 | -- | 44 |
| | 100% | 100% | 100% | 100% | 100% |
| Number of families | 70 | 45 | 20 | 32 | 167 |

## WERE PROBLEMS OF THE FAMILY MAINLY CHILD, ADULT OR BOTH?

The coders were also asked to make an overall judgment regarding the types of problems each parent had, using the following categories:

1. Problems only or primarily in interacting with the child. This included parents whose adult lives seemed to present no particular problems to them, although they were clearly having problems with their children, and, of course, in one sense would be affected by these. But they did not evidence personality or adjustment problems of their own. Included in this group were families with a child with suspected neurological deficits who presented very unusual or strange behaviors which the parents did not understand and could not handle satisfactorily, as well as some parents who were clearly lacking in understanding of child development.

2. Parents with primarily or only adult problems of their own, particularly in relationship with other persons, either spouse or mate, or with an ex-spouse or own parents. Although it may seem surprising that some families were referred when they did not show particular problems with their children, they were referred because in general they, themselves, felt they were having problems with their children and their own personal problems were clearly interfering with their making a satisfactory adjustment to the parenting role.

3. Problems both in interacting with their child and with their own adult lives. This variable was considered an ordinal scale; those having problems primarily with their children were regarded as having problems most likely to respond to intervention, those with primarily adult problems next, and those with both kinds of problems least likely (see Table 5).

Table 5

Types of Problems Described for Families in Each Group

| | HCT | FCS | FTP | OPT | Total |
|---|---|---|---|---|---|
| Primarily child problems | 53% | 33% | 45% | 31% | 43% |
| Primarily adult problems | 10 | 11 | 10 | 25 | 13 |
| Both child and adult problems | 37 | 56 | 40 | 41 | 43 |
| Not determined | -- | -- | 5 | 3 | 1 |
| | 100% | 100% | 100% | 100% | 100% |
| Number of Families | 70 | 45 | 20 | 32 | 167 |

The differences among the agencies do not reach a level of statistical significance, although somewhat more of the FCS families are described as having both child and adult problems than those in the other groups.

No relationship with the Degree of difficulty of the child or the presence of a Handicap was found. However, two characteristics of the mother were significantly correlated; Mother's childhood and Educational level of the mother (correlations of .305 and .287 respectively), indicating that those with lower educational achievement or with an unhappy childhood were somewhat more likely to have both kinds of problems in their lives.

Several additional questions were asked regarding the relative importance of these problems. One was a question about those families showing both child and adult problems: whether working only or primarily on child problems would be likely to be ineffective in such families. Coders judged that failure would be likely in 62 percent of all of these families, that it seemed necessary to work with them on both types of problems. For an additional 21 percent, the judgment was somewhat uncertain, but the coders indicated it was indeed preferable for the team to work on both problems. Whether the parent had actually asked for help with both child and adult problems was also noted. As might be expected, a relatively small proportion of parents did so, with the majority of those having both kinds of problems asking only for help with the child. A small group did not even acknowledge the existence of any personal problem and only indirectly asked for help with the child. It seems likely that the lack of recognition of adult problems would be related to the effectiveness of treatment.

Whether the parent acknowledged any part in the child's problem behavior is another item that would be expected to relate to outcome, as presumably such a parent would be motivated to work toward change. This judgment was not made for the FCS families. Half of those who were rated were described as not acknowledging any part in the child's behavior, that is, they gave no evidence of any understanding that their own behavior could be contributing to the child's behavior. Slightly over one-fourth felt they had contributed to it while a still smaller group, about one-tenth, questioned whether they might be contributing in some way to the child's behavior.

## THE USE OF KEGAN'S DEVELOPMENTAL THEORY IN DESCRIBING FAMILIES

A further step in analyzing the records, introduced by Lisa Lahey, a research associate during the first year of the project, was to develop codes that would describe the parent(s) and the child in developmental terms, using the system Robert Kegan had developed (Kegan, 1979; 1982). After learning of his work, we immediately became very interested in using his system if it seemed at all possible, as it provided a theoretical foundation for understanding where the parents were in their own development. This would have implications for what could and could not be expected of them in any training, because we would know something about their world view, for the parenting role. It also offered a way to increase our understanding of the individual child's needs which so often were clearly misunderstood by the particular parents involved. Considerable time was devoted to acquiring some understanding of Kegan's work and in coding, discussing, and reevaluating some of the early records studied as we did not want to use this method unless we could be reasonably reliable in applying these concepts. Through a fortunate coincidence, it was possible to arrange a day's consultation with Dr. Kegan early in the coding, which also contributed to our understanding of the material.

Table 6
Summary of Characteristics, Needs, and Level of Moral Behavior at Developmental Levels

| Typical age | Kegan's term for developmental "stage" | Primary characteristics of this level | Some of the primary needs of individual at this level | Level of moral development characteristic of this level (Kohlberg) |
|---|---|---|---|---|
| 2-4 | Impulsive | Child is an impulsive being; cannot separate from impulses. Fantasy is very important. | Warm nurturing; accept fantasies; close physical contact; non-pressuring, consistent efforts to teach child self-help. | Oriented to punishment and obedience |
| 5-7 | Transitional from impulsive to imperial | Shows gradually effort and desire to be self-sufficient, independent, and competent but also behaves impulsively at times. | Encouragement and "permission" to show self-sufficiency and independence; praise for attempts. Appreciation and warmth. | Still primarily punishment and obedience, but glimmers of of inner control developing. |
| 7 | Imperial | Gains great satisfaction from independence, self-sufficiency, show of competence (if these are positively recognized by others, especially parent). Plays by the rules. | Acceptance and positive recognition of competence, self-sufficiency. Assistance and encouragement to child when acquiring new skills. Permission to "try wings" within reasonable limits. | Instrumental, e.g. "you scratch my back and I'll scratch yours." Opportunistic; ready to take advantage of situations favorable to self and to help others. |
|  | Transition to Interpersonal | Gradual recognition that feelings and needs of another need to be taken into account; that another may have very different feelings. | Acceptance and encouragement of individual's attempts to take another's feelings into account; gradual development of "empathy" and "consideration." |  |
|  | Interpersonal | Attachment to another; behaves in terms of the other's feelings, needs, appraisal of self. | Acceptance and approval; needs to "belong," to have attachment recognized and valued. | Conforms to standards expected by the significant other(s), regardless of consequences. |
| Adulthood | Institutional | Has an identity separate from expectations of others; not dependent on another for definition of self. Has own goals, interests, as well as aware of those of others. | Opportunity to work for own goals, to achieve; recognizes needs and interests of others. | Aware of societal standards; lives by them; is generally conscientious. |

## The Developmental Level of Children[2]

Kegan's constructive-developmental theory is about personality development. It is called constructive because it refers to the way in which the individual "makes meaning" or constructs the world around himself/herself. Kegan has integrated much of the work in cognitive, ego, and moral development that has been widely accepted for years. Piaget's observations of how the growing child "makes sense" of the world around, and how such a child differentiates self from objects (Piaget, 1970), Loevinger's understanding of ego development (1976) and Kohlberg's understanding of the growing child's moral development (1972) have been integrated to provide a coherent view of the growing individual.

Although viewing growth as a continuing process, representing a lifelong attempt to resolve the basic issue of autonomy versus inclusion, Kegan also describes "stages" of development. These might be considered as providing a snapshot of a person's development, always in process, but which at a given time can be described in terms of the way the individual has defined the self in terms of subject-object. Being "subject" means you cannot mediate or take a perspective on whatever it is one is "being subject to." An example is a two-year old, who is his/her impulses. With development the child gradually makes the transition to "object," that is, being able to step outside these impulses and take control of them. This distinction will become clearer as the process of development is described.

The first "stage" beyond infancy is called the impulsive, generally typified by the child of approximately 2 - 4 years of age (Table 6).[3] Such a child is very egocentric, behaving impulsively, expressing curiosity and energy by exploring the environment, often without inhibition and, as language develops, creating fantasies which may be as important and "real" to the child as actual events. The child is his/her impulses and cannot be expected to understand them as desirable or undesirable. Toilet training and teaching the child self-care skills can be started but need to be in small increments and always accompanied by loving approval and encouragement.

Such a child may be perceived by a parent, however, as non-compliant, "naughty," or uncontrollable if the parent does not understand that impulsive behavior is to be expected and is quite normal at this age. This is a parent who is not "holding" the child appropriately, that is, not accompanying the child in his/her fantasy or providing the structure gradually needed by the child. Without these qualities in a caretaker, the child is likely to be confused, unpredictable, and easily upset.

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[2] We are particularly indebted to Lisa Lahey for her contributions to this phase of the research, including the development of the original codes and their application and assisting with the interpretations included here.

[3] In all of this discussion, it is important to regard the ages given only as approximations. Because holding environments can vary greatly, and offer differing opportunities for growth and expansion, children's (and also adults') development can show wide differences.

A period of transition from the impulsive to the next stage which Kegan calls "imperial," typically occupies several years, generally from about age 5 to 7. The child continues to show impulsive behavior but also some attempts at control, and begins to view his/her impulses as "object."

Obviously the environment, such as the need to start kindergarten, exerts pressure for change in the child. But the child needs to be "held," that is, provided with reasonable limits and structure as well as praised and encouraged for reasonable attempts to show control, that is, to sit still, listen, and do what is asked. The parent also needs to "let go," that is, permit the child to be self-sufficient and to show competence, even though the first attempts may be flawed. As the child moves closer to the self-sufficient stage, he/she may be more fearful of impulses re-appearing. Hence, an environment which excites the child's impulses or demands that the little sense of control he/she has earned be given up will be contrary to the child's needs. It may be particularly harmful as the child has more of a sense of self to feel failure at this point.

In order to become well established in the imperial stage, the child needs firm expectations and limits, and clear recognition for meeting them. Without a structured environment, it is very difficult for a child to move into the imperial level. Such an environment helps the child feel secure in attempts to control impulses, and provides the opportunity for the child to show competence. Recognition, through praise which recognizes the attempts at independence (not just praise for compliance), helps the child establish and maintain the feeling of competence and self-sufficiency.

At the imperial stage -- generally from about age 7 to 12 -- the child is his/her own authority, primarily interested in demonstrating competence. This child is ready to make bargains with others, to agree to rules of the game, but cannot be expected to take the feelings of others into account while they are taking their own into account. They cannot coordinate the two. When the child's own needs are at stake, the imperial child cannot be "considerate" of others. Such children are not so easily upset or frustrated by failure as long as they can control most situations. They are likely to choose playmates at this level of development and often do not find younger playmates adequate. However, some imperial children may demonstrate their competence through caring for younger children or teaching them.

The issue of control may be extremely important to an imperial child, and we see some who, without adequate structure within the family, attempt to control what the parent does, fight against limits, and behave aggressively. In one sense, the imperial is attempting to ascertain what the limits are.

Development level was coded only for children in HCT, FTP, and OPT families, none of whom had children beyond the imperial stage.

## Use of Developmental Theory in Describing the Parent

Since the first analysis of data was based on the HCT records, the most detailed of all the records available for study, it was possible also to apply Kegan's developmental theory to the parents, although we did this originally more as an experimental method to see if it might be possible. It would, of course, be desirable to know much more about the parents than is given in the records, although descriptions of the parents' responsiveness during treatment sessions provided considerable evidence regarding their ability to relate to others, and in what ways they were attached to others or dependent on others. They were described in the following ways.

The imperial stage is typically that of children about age 7 to 12, but some parents have remained at this level of development. Although they are functioning as adults in some ways, it is clear that they relate to others in ways characteristic of this stage. This means that they tend to be concrete in their thinking, viewing actions of themselves and others in terms of whether they are benefitted, and they often demonstrate a great desire to be in control. Concern with control occurs because the parent is subject to his/her own need systems and cannot take perspective on own needs and other's needs simultaneously. Consequently, if the parent can take control and predict what the other will do, he/she will do this. The imperial parent's own needs take priority.

If the idea of control is extremely important to them, they can be extremely upset when their child disobeys. If the child is at the impulsive level, the parent needs help in understanding that the child is too young to be expected to obey complicated directions or directions requiring great control of impulses. However, with a transitional child the parents may be able to make bargains and agreements with the child. Reward programs for these parents can be appropriate.

A parent at this stage may be negative toward and critical of their child and to have difficulty praising them or feeling empathy for the child, depending on whether the parent's needs are at stake. If they are, their own needs will take priority, and the parent will be unable to feel empathy for the child.

A few parents in this study were in transition from the imperial to the interpersonal stage, that is, clearly attempting to relate in more satisfactory ways to others and possibly to their children. They were developing sensitivity to others and learning to take the needs or purposes of others into account simultaneously with their own needs. This development requires a supportive, encouraging environment, in which the early attempts to take into account the feelings of another are accepted.

The interpersonal stage is typically reached during the late teen years, but may occur at any age in adulthood. The interpersonal individual is able to "share reality" with another or with several persons, but not yet able to separate own needs completely from those of another. Obligations, expectations, or satisfactions based on others predominate. This other person can be one's child, one's mate, one's parent, etc. The attachment to them, the dependence on what they say or decide or do, is so important that the individual is unable to stand back and say "I don't need to worry about what they think (or need)' I know what I want to do." An example is a mother who desired to keep her child dependent on her, finding her greatest satisfaction in being "needed" by this young child. One mother continued to think of herself as inadequate and incapable because of her own mother's poor opinion and constant criticism of her. And another interpersonal mother, dependent on her husband for her own feelings of self-worth, was able to be a reasonably competent mother because of her husband's support. One father, very attached to his wife (possible due to a previous miserable marriage) was willing to do almost anything to keep his imperial wife happy and could not see how her criticism of their son was affecting the boy so adversely.

The transition from the interpersonal to the institutional stage may occur at any time in adulthood. It is evidenced by the individual's gradually taking responsibility for his/her own preferences, behavior, and values -- moving away from being so dependent on another -- and becoming a separate self. This is not to suggest that the person is separating from other people, but rather separating from what he/she was subject to, that is, other people's expectations or needs. There is thus the ability for more extensive affiliation with others because there is not so much confusion of the "other" with self.

In the institutional stage, the person has a well defined notion of self and generally has reasonable self confidence or self esteem. The individual may be highly motivated to be a competent parent and, if so, may be an excellent one or at least is likely to respond well to training in parenting. But if the individual's priorities are in the direction of other goal attainments, such as developing a career, parenting may have a relatively low priority. This appeared to show particularly in a number of fathers in the study, whose interest and concern with their own work and activities was obviously more important to them than the parent role.

It also was apparent in the conflicts expressed by some mothers regarding the demands upon their time made by the training. They much preferred the activities of pursuing their own careers. In one instance, the team pointed out that foster care was an option if the single mother did not want to invest herself in parenting. But being a competent parent was also important to her. She did not accept this possibility and found that as her parenting improved, the interaction within the family became more pleasant and she had more time for her own interests.

A general observation on our particular culture is that the transition from imperial to interpersonal is likely to occur earlier in girls' development than in boys' as more emphasis is placed on the female's sensitivity and empathy with others. However, the transition from interpersonal to institutional seems more likely to occur earlier in male development, in which the emphasis on independence is greater. And the continued importance placed on sensitivity in females tends to make it more difficult for them to move on from the interpersonal level.

An attempt was made to code developmental level of both parents in the families served by HCT, FTP, and OPT. This detail was not included in the code used by the FCS staff as there was not sufficient time available for training them adequately. Even in the case of the data from the other three agencies, there was often not enough information to permit a rating of the father, but in the relatively small group of families for which this was possible (numbering 55), the correlation between the father's and mother's rating was .61. Rarely was there more than one step difference between them. For the analysis, the mothers' rating was used expect for the small number of single fathers, whose ratings were used if available.

The primary parents (mainly the mothers, but including the single fathers) in three agencies, HCT, FTP, and OPT, were nearly equally divided among the three developmental levels (Table 7). As might be expected, the mother's educational level is substantially correlated with her developmental level (an r of .42). The more highly educated mothers were significantly more likely to be rated at the institutional level and those with less education imperial. Slight, although significant, correlations (at better than the .05 level) indicate that older mothers and mothers who are employed are somewhat more likely to be rated at the institutional level. The composite score describing the Mother's Background (primarily her childhood) as being difficult or negative, as contrasted with warm and positive, shows a highly significant relationship with developmental level (an r of .40).

Table 7

Developmental Level of Primary Parents in Families Served By Three Agencies

| | Agency | | |
|---|---|---|---|
| | HCT | FTP | OPT |
| Developmental Level | | | |
| Imperial | 27% | 35% | 44% |
| Interpersonal | 32 | 35 | 16 |
| Institutional | 34 | 20 | 31 |
| Not determined | 7 | 10 | 9 |
| | 100% | 100% | 100% |
| Number of families | 70 | 20 | 32 |

The children, that is, the "targeted child" or, in the small number of families in which no child was selected, the oldest child, also represent a range of developmental levels (Table 8).

Table 8

Developmental Level of the "Targeted Child" (or, if none, the oldest) in Families Served by Three Agencies

| | Agency | | |
|---|---|---|---|
| | HCT | FTP | OPT |
| Developmental Level of child | | | |
| Incorporative[a] | -- | -- | 3% |
| Impulsive | 19% | 15% | 28 |
| Transitional from Impulsive to Imperial | 58 | 45 | 28 |
| Imperial | 23 | 35 | 41 |
| Not determined | -- | 5 | -- |
| | 100% | 100% | 100% |
| Number of families | 70 | 20 | 32 |

[a] This level of development, evidenced by one OPT child, is still earlier than the impulsive and is characterized by a "complete embeddedness in the life force" (Kegan, 1982, p. 121), in which the very young child is experiencing objects and persons as extension of the self and has not separated self from object.

Significantly, more of the children rated "very" or "extremely" difficult are found at the transitional or imperial developmental levels than at the impulsive (Table 9). This is, of course, related to the definition of Degree of difficulty used, although it was applied quite independently of any consideration of developmental level. Acting-out or hostile or aggressive behavior is more likely to be regarded as serious behavior in an older child, however, and is more likely to be resistive to change efforts.

Table 9

Relationship Between Degree of Difficulty Evidenced by Child and Child's Developmental Level

| | Of the children rated as | | | |
|---|---|---|---|---|
| | Difficult | Quite Difficult | Very Difficult | Extremely Difficult |
| Child's developmental level | | | | |
| Incorporative | -- | -- | 3% | -- |
| Impulsive | 39% | 25% | 17% | 4% |
| Transitional | 39 | 50 | 45 | 57 |
| Imperial | 22 | 25 | 35 | 39 |
| | 100% | 100% | 100% | 100% |
| Number of children | 18 | 48 | 29 | 26 |

## The Environment Provided the Child

In the preceding section, some references have been made to the "holding environment." This has been a particularly useful construct in describing the quality of the environment provided the child by the parent. Kegan (1982) attributes the term, "holding environment" to D.W. Winnecott (1965), who discussed it as an essential aspect of an infant's life, saying there is never "just an infant," but an infant being care for in a particular way. Winnicott is referring to what the child needs, a care-giver. Kegan has extended this concept to every point in development, believing it has significance throughout life.

Three functions of the parent are described by Kegan:

-- "Holding that is nurturing the child or meeting the child's needs at that point in the child's development. For the impulsive child this means nurturing the fantasy world of the child; for the imperial, nurturing the child's attempts at competence, self-sufficiency.

-- "Letting go" or providing contradictions to encourage the child's growth. For the impulsive, this means not meeting every need of the child, setting some limits, thus encouraging the child's becoming independent from his/her egocentric world embedded in impulses. For the imperial, this means encouraging child to begin taking another's needs into account, to see that the other may have a different point of view.

-- "Sticking around" or waiting unintrusively, in a sense implicitly assuring the child that the holding environment remains intact so that the child can return to it in a new way.

The parent's function in each of these ways changes as the child grows because the child's needs change. For example, an older child needs to be nurtured in a different way than a younger one, and the parent needs to "let go" of different aspects of a teenager's life than would be appropriate for a 7-year old. In addition, the parents are much more important to the young child because they constitute more of the holding environment. As the child grows, the holding environment includes much more than the parents.

The four ways in which we described the holding environment are the following:

1. Overholding, that is, not fulfilling the "letting go" function or not providing any contradiction that encourages the child to grow. Such mothers may have been caring well for their children, but as the children grow, fail to respond to their new needs. Examples are mothers of impulsive children who want them to remain "babies," so that they can dress them and take care of them. Or parents of a developmentally disabled child may not see any need to encourage the child to learn self-help skills, but continue doing everything for the child. A transitional child is overheld by parents who do not permit the child to attempt to show his/her competence or do not ask the child to do anything that provides a new challenge, only asking the child to do what he/she already does well.

2. Underholding-ignoring, or failing to meet the child's needs through inattention and uninvolvement in the child's world. For the impulsive child, this means a parent who has no part in the child's fantasy, and is providing no structure for the child. For the transitional child, the parent also is uninvolved, generally paying attention to the child only when the child's misbehavior or difficulty demands attention, and then scolding the child or asking "Why are you so bad?" In theoretical terms, the parent is asking too little of the new part of the child and too little of the old. The ignoring parent of the imperial child provides no feedback, no structure for the child. The ignoring parent has little or no awareness of children's needs.

3. Underholding-pushing, or expecting the child to be capable of more than he/she is, or, in some cases, expecting the child to understand the parent's needs and fulfill them. This can occur with a young child who is "expected" to become toilet-trained easily and quickly; or with a school age child who is expected to carry considerable responsibility in the household with no positive feedback given in recognition; or with the developmentally disabled child who is expected unrealistically to achieve beyond the level he/she is capable of. Several examples in the study were fathers who were sure their children had college potential and, therefore, spent night after night drilling a hapless child in arithmetic which appeared to have become meaningless to the child in a frantic effort to please the parent.

4. The nearly ideal environment was also observed in a few families, referred for study and help because of special problems they were having which puzzled them. Such an environment is always defined relative to the child's needs; it means that the parents were nearly meeting the child's needs adequately and appropriately. Examples were a couple with a retarded child for whom the possible diagnosis of autism had been given; they did not know how to react to their child because she did not respond in the expected way although they did not lack in nurturing. Another was a mother whose daughter was being returned from foster care after removal because of the mother's alcoholism. The mother needed help primarily with her own problems although the worker making the referral wanted to make sure that the mother could provide adequate care for her daughter.

In summary, a holding environment is inappropriate when the parent is unable to fulfill the developmental needs of the child or fails to perform any of the three functions described ("holding," "letting go," and "sticking around"). The degree of inappropriateness depends on which of the functions are not being fulfilled and to what degree. As we read the records, it seemed to us that much of the difficult behavior shown by the children studied could be attributed to the holding environment they were experiencing.

For example, a transitional child, trying to maintain control of his/her impulses and demonstrate self-sufficiency, but able to accomplish this only occasionally, and lacking any encouragement or positive attention for such efforts, may give in to impulsive behavior which is then perceived as obnoxious and destructive. Or an impulsive child 4 years of age, who is being overheld by a mother whose whole life is centered on this youngster, may yell and scream when the mother's attention is given to a friend visiting her. An inappropriate holding environment can lead to problem behaviors, although it is not the only problem that needs to be addressed in treatment.

The holding environment provided by parents served by the four agencies differ considerably (Table 10). More of the FCS parents are judged to be overholding their children -- not unexpected when so many of the children are developmentally disabled. Far fewer of the FCS parents are judged to be ignoring their children as compared with the parents in the other three groups. Ignoring is most prominent in the FTP families, who, along with the OPT families, are less likely to consist of two biological parents in the home.

The question that is immediately raised is the relationship between the kind of environment provided the child, and the child's own characteristics in terms of developmental level and degree of difficulty. In all of this discussion, it is the "targeted child" or, if no one child is so identified, the oldest child in the family group, that is being described.

Table 10

Kinds of Holding Environment Provided by Primary Parents
Served by the Four Agencies

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| Environment provided by parent | | | | |
| Overholding | 20% | 35% | 5% | 9% |
| Underholding-ignoring | 54 | 20 | 80 | 54 |
| Underholding-pushing | 22 | 31 | 15 | 22 |
| Nearly ideal | 4 | 7 | -- | 9 |
| Not determined | -- | 7 | -- | 6 |
| Number of families | 70 | 45 | 20 | 32 |

There is no relationship between the primary parent's developmental level and that of the child (r of .01), and there is no relationship between the kind of environment provided the child and the child's developmental level. Half or more of the child experiencing each of the three holding environments are at the transitional level. Since developmental level was not coded for the FCS children or parents, only 109 cases can be examined for these effects.

There is a distinct relationship between the holding environment provided by the primary parent and their developmental level (Table 11). Over half of the overholding mothers[4] are rated at the interpersonal level. This suggests that they are particularly involved in their children's lives, attending to their needs and wishes, and not encouraging the children to move on in their development. The mothers who are described as underholding their children -- through ignoring or pushing them -- are predominantly at the imperial level, with nearly equal proportions of these two groups found at the interpersonal or institutional level.

Table 11

Relationship Between Environment Provided by the Primary Parent the Developmental Level of the Parent

| | Holding Environment | | | |
|---|---|---|---|---|
| | Over- holding | Underholding | | Nearly Ideal |
| | | Ignoring | Pushing | |
| Mothers' developmental level | | | | |
| Imperial | 17% | 43% | 43% | -- |
| Interpersonal | 55 | 27 | 30 | -- |
| Institutional | 28 | 30 | 27 | 100% |
| Number of mothers | 18 | 63 | 23 | 6 |

---

[4] We refer to the primary parents and mothers interchangeably as all but a few single fathers (6 in number) and three fathers in FCS families who were the focus of treatment.

From the tabulation showing the relationship of the Degree of difficulty of the child with the Holding environment (Table 12), it is evident that over half of the children who are being overheld or ignored are rated as "very" or "extremely" difficult. This is a somewhat larger proportion of the children rated at these levels than shown in Table 4, but not significantly larger. Those who are being "pushed," however, are rated significantly less difficult than those in the other two groups. It is not surprising that a larger proportion of the children being overheld are Handicapped then of those in the other two groups (Table 13).

Table 12

Relationship Between Environment Provided Child and Rating of Degree of Difficulty Shown By Child

| | Holding Environment | | | |
|---|---|---|---|---|
| | Over-holding | Underholding | | Nearly Ideal |
| | | Ignoring | Pushing | |
| Rating of degree of difficulty shown by child | | | | |
| Difficult | 12% | 9% | 23% | 44% |
| Quite difficult | 32 | 37 | 41 | 33 |
| Very difficult | 18 | 26 | 31 | 22 |
| Extremely difficult | 38 | 27 | 5 | -- |
| | 100% | 100% | 100% | 100% |
| Number of children | 34 | 80 | 39 | 9 |

Table 13

Relationship Between Environment Provided Child and Presence of Handicap

| | Holding Environment | | | |
|---|---|---|---|---|
| | Over-holding | Underholding | | Nearly Ideal |
| | | Ignoring | Pushing | |
| Is child handicapped? | | | | |
| No | 32% | 76% | 69% | 67% |
| Yes | 68 | 24 | 31 | 33 |
| | 100% | 100% | 100% | 100% |
| Number of children | 34 | 80 | 39 | 9 |

We not only attempted to categorize the holding environment being provided the child at the beginning of treatment, but also attempted to describe in some detail its main characteristics, that is, what distinguished it, and what seemed to be the basis for the parent's holding style in terms of the parent's own needs that were being served. The latter were called "core problems," that is, problem areas of the parent that would need to change or be at least partially resolved if the environment were to be improved. These could be described here, but since they are of particular relevance in examining the changes occurring during the intervention with each family, they are presented in Chapter V.

# CHAPTER IV
# THE PROCESS OF INTERVENTION

How did the agencies go about working with each family, once the family and agency had agreed to work together? This was possibly the most difficult question raised by the research because of the lack of adequate methods to describe the process of treatment. Only one agency, the HCT group, has attempted to describe its methods of intervention in detail (The Home and Community Treatment Process: Helping Families Change, 1979), but even this write-up contains very little reference to a variety of parent problems to which the staff was sensitive and would offer counseling and support. There is no such detailed description of the methods used by the other three groups.

Rather than a case history of the entire process of intervention, then, we have a number of different kinds of evidence regarding the work that was done. It is described under the following headings:

1. A comparison of the methods used by the four groups.
2. Evidence of defensiveness shown by the parents and support provided by the staff during intervention.
3. The length, intensity, and location of treatment.
4. Did treatment continue as long as staff believed it important?
5. The goals of treatment as evidence of methods used.

## A COMPARISON OF THE METHODS USED BY THE FOUR GROUPS

We experimented with a number of techniques, first trying to describe each contact in terms of the emphasis in the training and methods used. This proved impossible, at least within the constraints of time and staff available, as generally a number of different methods would be used in each training session. Often we found there were no satisfactory ways of describing what seemed to us the essential part of a particular session, and developing an objective code for this purpose appeared extremely difficult. Consequently, work directed toward coding and analyzing the methods used in working with families ceased until we had had considerable experience with the HCT data. At that point a list was developed to describe the various kinds of methods used in the training sessions with the parents alone, parents and children together, with the child alone, and with the parents in conjunction with others outside the immediate family (Table 14). This was shared with the HCT staff, who suggested some additions, and then it was used in coding the records of 20 HCT families. These were not a random selection, but happened to be the 20 cases still to be coded at the time.

However, they include families from every year of intake covering the entire period studied with the exception of one year. The relative emphasis given to each method was rated on a five point scale and a zero was coded if there was no evidence that the particular method had been used with the family.

Since this technique had been developed by the time the FCS staff began their coding, they were asked to indicate the relative importance of each method with each family as the data were coded. This means that nearly all of the FCS families were rated according to the list of methods provided.

The technique of describing the methods used by FTP and OPT is somewhat less satisfactory. Since there had been a complete changeover in FTP staff at the beginning of 1980, both the present director and the previous leader of the staff were given the list of methods developed and were asked independently to rate the relative importance attributed to each of these methods in their work. Although many of their ratings agreed closely, there were some marked differences in regard to their work with the individual child. The present staff leader explained that their current emphasis is on teaching the parent to work with the child and to provide special training or experiences for the child rather than expecting the staff to perform these functions. Since the earlier group had provided the intervention with 75 percent of the families included in this study, however, we have used their ratings to describe the methods used. For the OPT data, the ratings as to relative emphasis were made by the OPT project director and represent one person's summary of the variety of methods used by that group.

One way in which the relative emphasis of the treatment methods can be assessed is to create an average score of emphasis within each of these groups of methods, also shown in Table 14. When this is done, the greatest emphasis seems to be on methods describing work with the parents alone. Within this group didactic instruction receives the highest rating for all four agencies. This method includes teaching principles of behavior change, of normal child development, and ways of understanding children's behavior. Exercises from Becker's (1976) or Patterson's (1976) books were frequently used by OPT staff.

The techniques used to present didactic instruction also differed. FCS typically used group instruction whenever possible, meeting with the family individually only if there were no other families ready for such training at the time. They provided this training in the beginning of work with some families and during the early part of work with others, particularly if postponement meant that a family could attend group training. The HCT staff typically placed great emphasis on didactic training at the beginning of their work with the family, bringing the family into their offices for instructions and for actual trying out some of the methods being taught.

Following didactic training closely is counseling regarding both parenting problems and non-parenting problems. Because of the differences in the techniques used to assess the methods used in the different agencies, it seems unwise to emphasize small differences between agencies. It does appear, however, that both HCT and OPT used more direct teaching regarding parenting problems, teaching parents coping skills, how to solve problems that came up, etc., than the other two agencies.

Next in importance, and probably not very different in relative importance, is work with the parents and the targeted child together. It appears that HCT and FTP placed relatively more emphasis on this than FCS and OPT. This could at least in part be attributed to the differences in age of the targeted children served by OPT and FCS. The OPT children tended to be younger, so that work with the parents of the young pre-school child would be primarily with the parent, teaching the parents appropriate ways to care and interact with a young child. The FCS targeted children, on the other hand, were the oldest, and although family sessions were typically held once a week with the entire family, much of the emphasis in treatment was on individual work with the youth. Since the FCS staff had a staff member who concentrated on providing social experiences and social skills training for their targeted client, this would be expected to receive more emphasis. The provision of fun experiences and working out a reward system for the targeted child by OPT could just as easily be considered working with the parents and child together as both of these approaches generally included the parents.

Working with the schools appeared to receive lower emphasis in each of the agencies except for FCS. This is not surprising as FCS had one staff member who had been a teacher and whose primary responsibility was to meet with school staff, find out how the targeted youth was getting along in school, and when indicated, work out agreements between the school and youth. Concentrated work with the schools was carried out by HCT for 28 percent of the children. In these instances, the HCT staff spent considerable time in the school classroom observing the targeted child, and working out specific plans for interaction with the child by all school personnel. This cooperative effort seemed particularly important in handling one boy's severe behavior problems in the school setting.

Table 14

Relative Emphasis of Treatment Methods Used by Four Agencies[a]

|  | Agencies |  |  |  |
|---|---|---|---|---|
|  | HCT | FCS | FTP | OPT |
| With parent(s) alone |  |  |  |  |
| 1. Didactic instruction | 5 | 5 | 5 | 5 |
| 2. Use of analogue situations for training (e.g., role play, staff modeling in "pretend" situation, coaching and cueing parent) | 4 | 1 | 5 | 3 |
| 3. Teaching regarding parenting problems (coping skills, problem-solving skills, having to do with interacting with child, providing adequate or satisfactory environment for child, etc.) | 5 | 2 | 3 | 5 |
| 4. Counseling regarding parenting problems (e.g., feelings about child or IP, difficulty in changing habit patterns, etc., parent role) | 4 | 5 | 5 | 4 |
| 5. Counseling regarding non-parenting problem (e.g., feelings about self, own self-confidence, marital relationship, relationship with own parent or other extended family member, etc.) | 4 | 5 | 5 | 3 |
| 6. Accompanying parents to confer with school | 0 | 3 | 1 | 1 |
| 7. Completed homework regarding child management techniques and/or play | 4 | 0 | 0 | 0 |
| Average score emphasis parent(s) alone | 4.3 | 3.5 | 4.0 | 3.5 |
| With parent(s) and IP together |  |  |  |  |
| 1. Coaching and cueing parent regarding handling of actual behavior of IP | 5 | 4 | 5 | 3 |
| 2. Handling of discipline situation when need occurs (to demonstrate to parent) | 3 | 3 | 5 | 1 |

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[a] The relative emphasis is shown by a scale of 1 through 5 for each item, 5 showing considerable emphasis in a particular method by an agency and 1 showing little or no emphasis.

Table 14 (continued)

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| 3. Introducing game or other activity to parent and IP | 2 | 1 | 3 | 5 |
| 4. Accompanying family (parent and IP, possibly others) on recreational or social outing | 1 | 3 | 3 | 4 |
| 5. Accompanying family (parent and IP) to meeting with school personnel | 0 | 1 | 1 | 1 |
| 6. Accompanying family (parent and IP) to meeting with other professional or organization | 0 | 2 | 1 | 0 |
| 7. Facilitating joint problem-solving or planning by parent and IP | 1 | 1 | 3 | 1 |
| 8. Using analogue situation with parent and IP for purpose of teaching (i.e. role playing, presenting a new game parent is to teach IP, etc.) | 4 | 0 | 5 | 2 |
| 9. Bringing in other members of family in addition to parent(s) and IP to obtain their cooperation in carrying out treatment plans | 0 | 3 | 3 | 0 |
| 10. Program for child; parent implements | 3 | 0 | 0 | 0 |
| 11. Data taking trials for purpose of feedback | 5 | 0 | 0 | 0 |
| Average score emphasis parent(s) and IP together | 3.0 | 2.25 | 3.4 | 2.25 |
| With IP or child alone[b] | | | | |
| 1. Teaching IP coping skills (e.g., cognitive self-instruction) for handling problem situations or own problem behavior (such as impulsive behavior) | 2 | 3 | 3 | 1 |
| 2. Teaching IP social skills - pertaining to interaction with others or behavior in social situations | 0 | 4 | 5 | 1 |
| 3. Teaching IP self-help skills (e.g., regarding cleanliness, appearance, appropriate dress, etc.) | 0 | 2 | 3 | 1 |
| 4. Providing age-appropriate experiences for IP (trips to zoo, library, stores) | 2 | 4 | 3 | 3 |

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[b] Emphasis on this has changed considerably for FTP in which staff how places their entire emphasis on teaching the parent to train or help the child.

Table 14 (concluded)

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| 5. Providing fun experiences for IP (playing games, fun activities) | 3 | 4 | 3 | 3 |
| 6. Providing counseling or talk therapy for IP | 1 | 4 | 1 | 0 |
| 7. Providing play therapy in appropriate setting (playroom for that purpose) | 1 | 1 | 3 | 0 |
| 8. Work out reward system for IP | 5 | 2 | 5 | 5 |
| 9. Accompanying IP to meeting with school personnel regarding school program, behavior, etc. | 0 | 1 | 1 | 0 |
| Average score emphasis child alone | 2.3 | 2.8 | 3.2 | 2.6 |
| With school | | | | |
| 1. Planning specific agreement with school regarding attendance or behavior (i.e., what is to be expected of IP) | 3 | 5 | 1 | 2 |
| 2. Planning specific agreement regarding contingencies for certain behavior or attendance | 0 | 4 | 1 | 0 |
| 3. Involving peers of IP in discussion and in making agreement | 0 | 1 | 1 | 0 |
| 4. Searching for appropriate placement for IP | 0 | 2 | 1 | 0 |
| 5. Keeping in touch with school to learn about their program for IP and IP's reactions to it | 3 | 5 | 1 | 2 |
| 6. Working out specific reinforcement program with school personnel | 2 | 3 | 1 | 0 |
| 7. Working out contingency plans for behavior management of IP | 0 | 4 | 1 | 0 |
| 8. Accompanying IP to confer with school staff member(s) | 0 | 2 | 1 | 0 |
| 9. Training school staff | 1 | 0 | 0 | 0 |
| 10. Data collection | 2 | 0 | 0 | 0 |
| 11. Modeling | 2 | 0 | 0 | 0 |
| Average score emphasis with school | 2.2 | 3.25 | 1.0 | 0 |

## EVIDENCE OF DEFENSIVENESS SHOWN BY THE PARENTS AND SUPPORT PROVIDED BY THE STAFF DURING INTERVENTION

During the early work with the records, the coders noted a marked difference among parents in their readiness to try the changes or methods suggested by staff, and their openness to new interpretations of reasons for their child's behavior. This quality of resistance was called "defensiveness" and included such behavior as being late for appointments, failing to show for appointments, not doing assignments, or going along reluctantly with specific practice during training sessions, and the like. The coders were alert to such signs on the part of each parent during the entire treatment as they read the entire record. Their ratings are summarized in Table 15.

Table 15

Is There Evidence of Defensiveness on the Mother's Part?

| | HCT | FCS | FTP | OPT | Total |
|---|---|---|---|---|---|
| Yes, clear evidence | 23% | 7% | 10% | 35% | 20% |
| Yes, some evidence | 23 | 22 | 50 | 34 | 28 |
| No evidence | 54 | 56 | 35 | 28 | 47 |
| Not enough information | -- | 15 | 5 | 3 | 5 |
| | 100% | 100% | 100% | 100% | 100% |
| Number of families | 70 | 45 | 20 | 32 | 167 |

Unfortunately, the code used for the FCS and FTP data was not identical to that used for the HCT and OPT records. It is quite possible that more of the FCS and FTP families might have been coded as showing "clear evidence" had the other code been used, but we did not have information at hand to justify making any such change in the original coding. The "no evidence" code was the same for all four groups.

A similar rating was made for the fathers, but since at least one-third of the ratings could not be made either for lack of information or because there was no father figure in the home, this information is of relatively little use in any statistical analysis. However, it is of interest to note that the correlation between the resistance on the part of the two parents for the total group for whom this information was available was .374.

### Role of Staff

Another dimension of treatment is the extent of support provided the parents by the staff. Any attempt to help parents change either in respect to their own attitudes towards themselves and their problem areas, or even in interaction with their children, is likely to be difficult and often painful for the individual. For this reason staff support would seem to be an essential ingredient of such change. At the same time, it is recognized that the characteristics of a client undoubtedly affect the staff member's attitude and ability to establish rapport, just as the staff member's concern for the client has an effect on the client's willingness to work in the directions suggested.

The most satisfactory way of obtaining a measure of this dimension would be, of course, from the clients themselves, but this was not possible. The coders made a judgment based on evidence given in the records. This that the staff members gave included evidence of empathy for a client and readiness to help when a crisis or emergency or a particularly difficult situation arose. This judgment was made only for the HCT and FTP families. Sixty percent of the families were rated as receiving considerable support and encouragement from staff and only 6 percent as receiving relatively little support, with the remainder rated as receiving some support.

### Involvement of Father

Other information describing the process of treatment is the degree of effort made to involve the father in treatment, when there was a father figure in the home, and the extent to which he responded to this. This rating was also made just for two agencies, HCT and OPT. In nearly two-thirds of the families in which a father was present, the staff made a considerable effort to involve him in treatment. This was in keeping with the philosophy of both HCT and OPT regarding the importance of including all family members in any intervention. In less than ten percent of the families was there little or no attempt to involve the father. However, in fewer than 30 percent of the families with fathers present was his response to these attempts judged to be very favorable, and in fewer than one-fourth more of the families was the father ever coded as somewhat responsive. We see later in the analysis that the attitude of the father was highly related both to completion of treatment and measures of outcome in two parent families.

## LENGTH, INTENSITY, AND LOCATION OF SERVICE TO FAMILIES

Length and intensity of service to families was coded in terms of time and staff effort devoted to each family, including the length of time in months that the family was involved with staff, the number of contacts, and the record of hours worked.

The determination of length of treatment poses difficult questions in itself as each group devoted some time in making observations of family interaction, and even at times, waiting for the family to decide whether they wanted to participate in the program. Illness, surgery for acute appendicitis, and a new baby produced a delay in starting with some families after they had agreed to participate. However, when the alternative of selecting another beginning date for determining the length of treatment, there seemed to be even more problems in defining just when it should be. Contacts with a family, even if for the purpose of an initial interview (as in OPT), or for observations (used by every agency) could possibly have some effect.

After considering alternatives, and examining the available data from the four agencies, we decided to use the first date of personal contact with a

67

family as the beginning of work with them, and the date of the last personal contact as the ending date. This latter may not coincide with the official date of termination shown in the record, which may also depend on a variety of factors as, for example, a staff's decision that no further contact with the family is warranted since the family has declined to work any longer, or a delay in obtaining the official signature on the final summary.

## Length of Service

The number of months and the total hours spent working with the average family show some marked and significant similarities and differences across agencies. Three of the agencies (HCT, FCS, FTP) do not differ significantly from each other in terms of length of time a family is in treatment, with their overall average time just under 1 year (Table 16). The OPT treatment process, limited by design to a period of 8 to 12 weeks after the initial interview and observations, was markedly different in that the average number of months a family was seen, as defined by the first and last personal contact, was 3.97 months. The longest time a family was seen approached 3 years in both HCT and FCS but was only 18 months for FTP and under 6 months for OPT.

Table 16

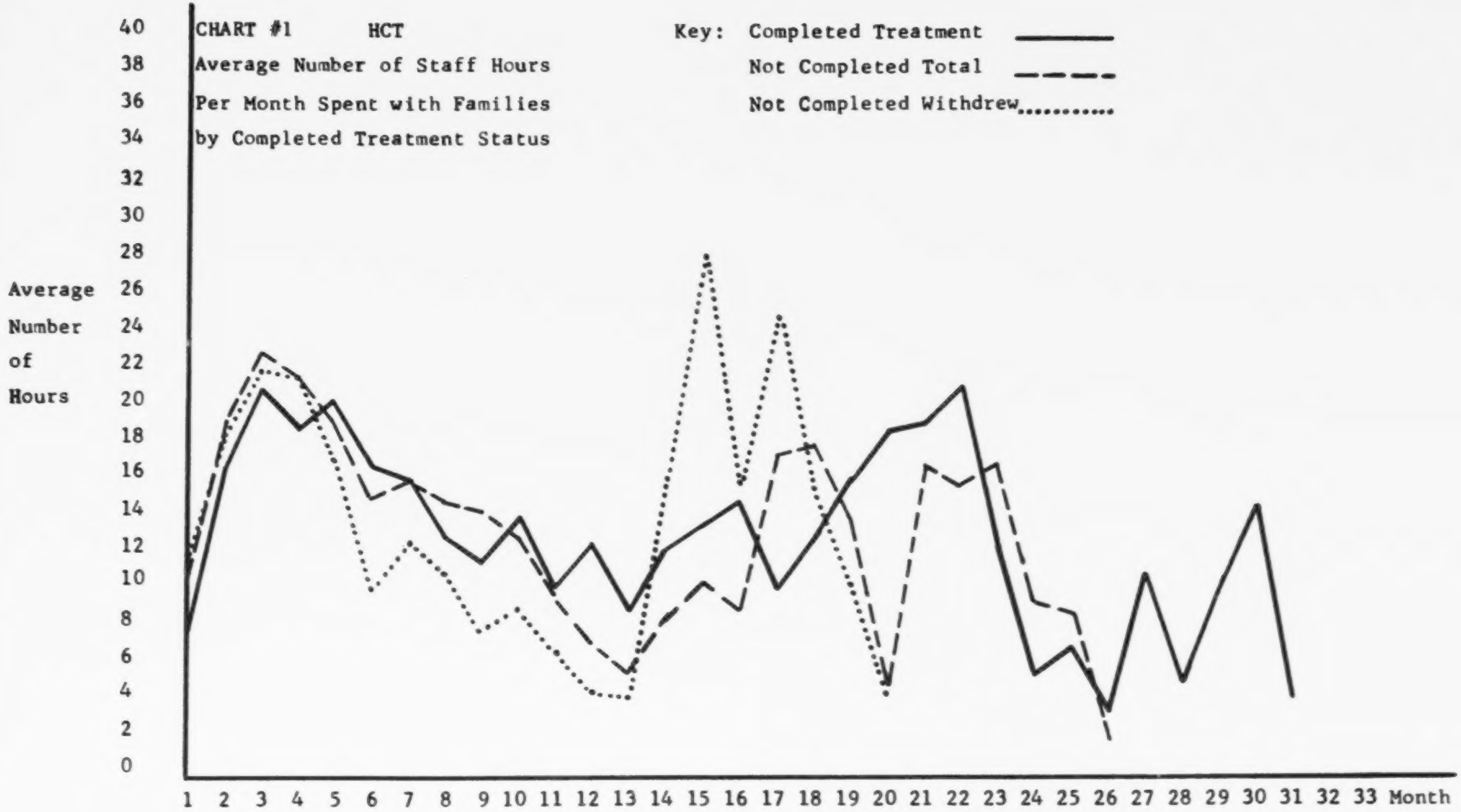
Length and Intensity of Service to Families by Agency

| | | HCT | FCS | FTP | OPT | TOTAL |
|---|---|---|---|---|---|---|
| Average length of treatment (months) | Mean = | 11.25 | 12.31 | 9.5 | 3.97** | 9.66 |
| | S.D. = | 6.9 | 7.8 | 4.5 | 1.1 | 7.1 |
| Cases Missing | | 2 | 2 | 0 | 0 | 0 |
| Average number of staff hours per family (not including case planning) | Mean = | 186* | 282* | | 46* | 188 |
| | S.D. = | 128 | 229 | | 23 | 177 |
| Cases Missing | | 2 | 0 | 20 | 3 | 25 |
| Average number of contacts per family | Mean = | 79 | | | 29 | 79 |
| | S.D. = | 54 | | | | 54 |
| Cases Missing | | 2 | 45 | 20 | | 99 |

*F significantly different at .01 level from one or more of three agencies, ONEWAY Anova

**F significantly different at .000 level from one or more of three agencies, ONEWAY Anova

The vast majority of families for these three agencies with longer treatment remained in service for at least 6 months (Table 17). However, by the end of one year over one-half of HCT cases, over one-third of FCS, and nearly all of the FTP cases were closed. At 18 months, one-quarter of FCS cases remained open, one-fifth of HCT and only one-tenth of FTP families were continuing work with the agency.



| Month | Completed | Not Completed | Withdrawn |
|---|---|---|---|
| 1 | 33 | 35 | 20 |
| 2 | 33 | 35 | 20 |
| 3 | 33 | 35 | 20 |
| 4 | 32 | 33 | 18 |
| 5 | 31 | 32 | 17 |
| 6 | 30 | 28 | 16 |
| 7 | 30 | 24 | 14 |
| 8 | 30 | 19 | 10 |
| 9 | 27 | 17 | 9 |
| 10 | 25 | 14 | 6 |
| 11 | 23 | 13 | 5 |
| 12 | 19 | 13 | 5 |
| 13 | 18 | 12 | 4 |
| 14 | 16 | 11 | 3 |
| 15 | 13 | 10 | 2 |
| 16 | 11 | 7 | 2 |
| 17 | 11 | 5 | 2 |
| 18 | 10 | 3 | 2 |
| 19 | 9 | 3 | 2 |
| 20 | 8 | 2 | 1 |
| 21 | 7 | 1 | |
| 22 | 7 | 1 | |
| 23 | 6 | 1 | |
| 24 | 5 | 1 | |
| 25 | 3 | 1 | |
| 26 | 3 | 1 | |
| 27 | 3 | | |
| 28 | 3 | | |
| 29 | 2 | | |
| 30 | 2 | | |
| 31 | 1 | | |
| 32 | | | |
| 33 | | | |

Number of Cases

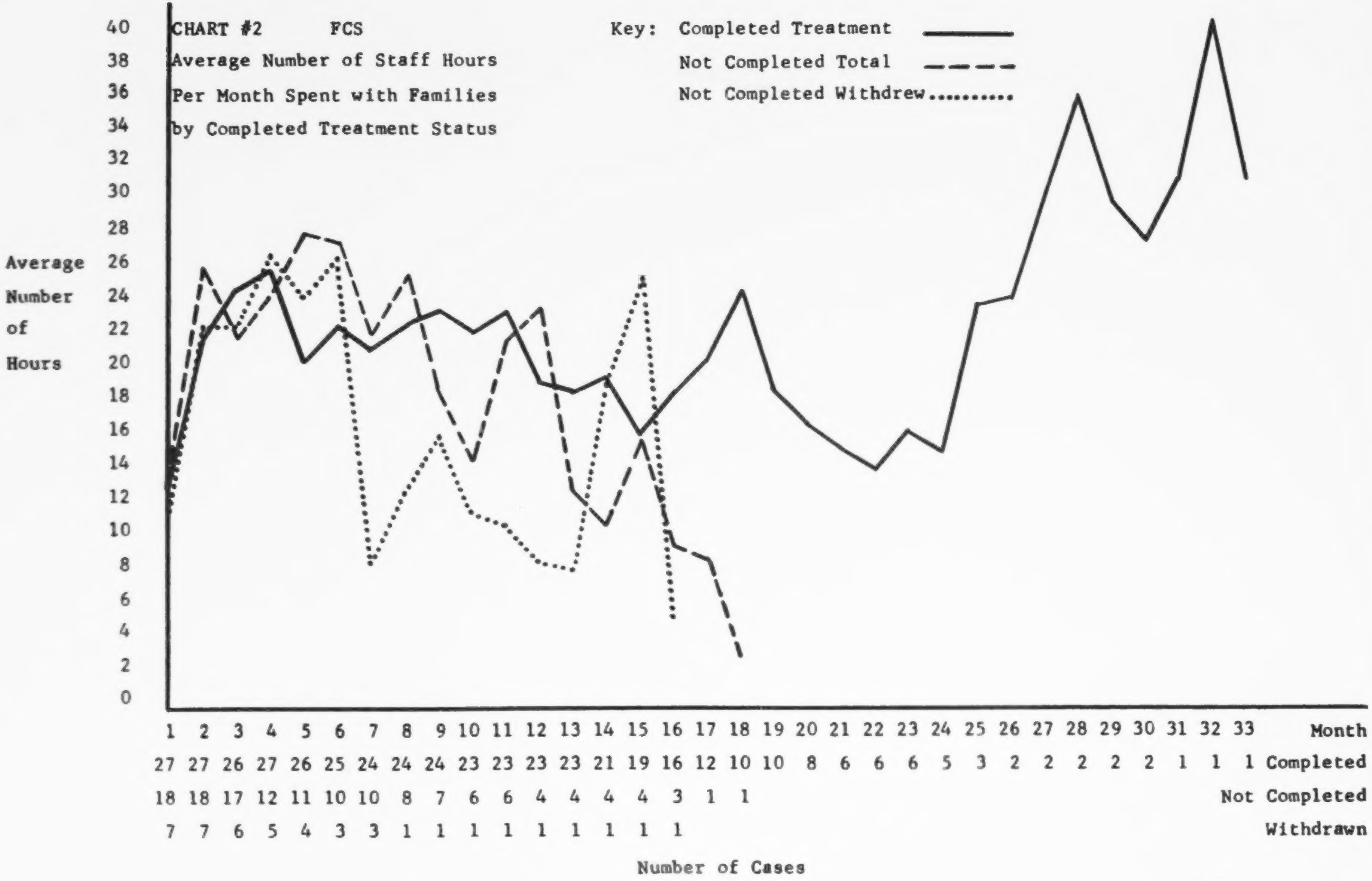


CHART #2 FCS

Average Number of Staff Hours Per Month Spent with Families by Completed Treatment Status

Table 17

The Percentage of Families Who Continued to Receive Services in 6 Month Increments by Agency

|  | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| Families receiving services for: |  |  |  |  |
| 6 months | 85% | 78% | 70% | 0% |
| 12 months | 47 | 60 | 15 | 0 |
| 18 months | 19 | 24 | 10 | 0 |
| 24 months | 9 | 11 | 0 | 0 |
| Average length of service to families in months | 11.25 | 12.31 | 9.50 | 3.97 |

When the total number of hours spent in working with each family are averaged, it is clear that each agency differs significantly from the others (Table 16). It should be noted that this total refers to direct contacts with clients or collaterals and does not include case planning time.

HCT and FCS differed to some extent in their use of staff, doubtless related to the differences in clients served. For most HCT families, two staff members worked together as a team; hence the hours of staff time were doubled for many contacts. FCS families were also seen by a team but the DD child/youth was generally seen by only one staff member for social skills training. Unfortunately, FCS records were maintained only for hours spent with a family so we do not know the average number of contacts.

The FCS staff spent an average of over 90 hours more with a family than HCT did even though they saw families on the average only one month longer and the time spent was more often with one staff member rather than a team. On a monthly basis, the FCS staff averaged more time with client families (Charts 1 and 2). In the first year, their staff averaged seven more hours per month with the families than HCT, that is, an average of 22 hours per month as compared with an average of 15 hours per month spent by HCT personnel during the first year. In the second year, the differences are less; the average is 17.5 hours per month for FCS and 13.4 hours for HCT. For months 25 to 31, however, HCT averaged eight hours per month while FCS increased to nearly 31 hours per month for months 25 to 33. This is a difference of 23 hours per month over the last 7 to 9 months of treatment. However, very few families in each agency remained in treatment this long; four for HCT and three for FCS. As a group, they represent a considerable amount of staff effort. Both length of treatment and number of hours spent with families will be examined in terms of their relationship to outcome.

The OPT staff spent an average of 46 hours with a family, a function of the shorter period of time in which they were able to work. We do not have information regarding the pattern of number of hours per month. This information was also not available in a precise form for FTP.

In determining the number of hours staff worked with a family, case planning time was not included because it was available for only one agency, HCT, whose staff spent an average of 56 hours planning their work with each family. When the planning time and time spent working with the families is added together for HCT, the grand total of time spent in work with a family served by that agency averaged 242 hours.

### Contacts with Families

The number of contacts a family had with staff members averaged 79 for HCT and 29 for OPT. This information was not available for the other two agencies. With an average treatment length of 11.25 months for HCT, and 3.97 months for OPT, this meant an average of about seven meetings a month or two contacts per week for both agencies.

### Location of Service

The HCT staff met with families at the agency nearly as often as in the home, and spent a relatively small percentage of time with collaterals (including schools, social agencies, and others), while the FCS staff met with families mainly in the home but also spent about one-third of their time in community contacts. FTP and OPT staffs worked almost exclusively with families in their own homes and had relatively few collateral contacts.

A typical pattern of service for HCT was first to meet with the family at the Institute for didactic training, teaching the parents some of the principles of behavior change, demonstrating the use of the principles in direct interaction with the child, followed by asking the parents to try them out while carrying on an activity with the child. Advantages of the office use were the controlled environment (no interruptions such as phone calls) and the availability of one way vision screens for unintrusive observations, particularly helpful in the training provided to graduate students by this group.

## DID TREATMENT CONTINUE AS LONG AS STAFF BELIEVED IT IMPORTANT?

The question of how long treatment lasted is complicated by the differing needs of families. Some problems need a longer period of work than others. It also differed with the mode of operation of the agency. Some agencies had a longer period of time to work with families, some agencies such as OPT and FTP did not intend to work with families for long periods of time. In order to take these factors into account, each family was coded on the question of whether the work with them ended before the staff believed it should have. If not, these families are defined as having completed treatment. If they did not complete treatment, the records generally made clear whether the family withdrew from treatment because they did not want to continue or whether treatment was stopped for other reasons, such as illness or the family's moving from area. Separate categories were used to identify these two groups of families with whom the staff would have preferred to work longer, in order to determine whether and how they differ from each other and from those who worked as long as the staff believed it worthwhile.

Out of the total group of families, across agencies, approximately 54 percent completed treatment, with little variation among the agencies (Table 18). The overall 26 percent who withdrew and 20 percent who did not complete treatment for other reasons were also similar for all agencies even though the average length of treatment for the individual agencies varied from 3.97 months to 12.3 months.

Table 18

Proportion of Families Who Completed Treatment, Withdrew, or Stopped Treatment for Other Reasons

| | Average Length of treatment in Months | Overall Percentage of Cases | Number of Families |
|---|---|---|---|
| Withdrew | 5.95 | 26% | 42 |
| Other did not complete | 8.89 | 20% | 33 |
| Completed | 12.14* | 54% | 90 |
| All families | 9.92 | 100% | 165 |

*F Significant at .000 level from group that withdrew, ONEWAY Anova.

The average number of months of service for those who completed treatment was significantly longer than that for the families who withdrew from treatment (Table 18). Those who dropped out for other reasons showed an average three months shorter than those who completed treatment. There are no significant differences between the two groups who did not complete treatment.

For those agencies for which we have number of hours spent by month, the pattern of number of hours spent both with families who completed treatment and the total group of families served is very similar, only varying by one-half to one hour per month in HCT and FCS throughout treatment (see Charts 1 and 2). Families who completed treatment received a significantly greater number of hours of treatment when compared with the total group, however, mainly because they were in treatment longer. This is especially true for FCS whose staff appeared to intensify their efforts at the end of treatment as compared to the HCT staff who reduced the numbers of hours at the end.

From information coded in the records regarding family characteristics, problems presented by parent and child, and treatment goals, it is possible to discriminate somewhat between families who are likely to complete treatment and those who are likely to withdraw or drop out for other reasons.

Early indicators of possible withdrawal from treatment may be most useful to the practitioner who could then respond to a family in a manner encouraging continuation of treatment, or overcoming some of the barriers that these factors represent. A family having one or more of these characteristics will not necessarily withdraw from treatment. However, some of these factors alone or in combination with others are strongly associated with early withdrawal and accounted for over one-third of the variance between families who completed treatment and those who withdrew. This discussion will take into account only information which is available early in treatment, since it is believed that the ability to distinguish between these groups is most useful early in treatment before families actually decide to withdraw.

The relationship of variables with service completion is based on correlations found in the analysis. In general, characteristics correlated at a significance level of .01 or better are discussed as significantly related to each other; those between .01 and .05 are considered somewhat related, and those between .05 and .10 as possibly related although not significantly.

## Relationship of reasons for referral and non-completion of treatment

Evidence that emphasis on the problems the parents are having with their children and the child's behavior in school may be somewhat threatening is found in the somewhat higher proportion of the groups referred for these reasons who withdrew from treatment. Thirty-five percent of them did so, as compared with 26 percent of the group referred because of the child's difficult behavior in the home of the child's developmental delay. Differences between these two groups are even greater when one looks at the proportion of families who completed treatment, that is, stayed in treatment as long as the staff believed it worthwhile. Sixty-four percent of those referred because of the child's behavior in the home or the child's developmental delay remained in treatment, whereas only 46 percent of those referred because of the parents' problems or the child's difficult behavior in school completed treatment.

## Family characteristics and non-completion of treatment

When the characteristics of the total group of families for all four agencies are examined, the composition of the family makes no difference as to treatment completion or withdrawal. One or two parent families are just as likely to complete treatment, and families in which the adults are married and are the biological parents of the child are no more likely to finish than step-parent families or single parents with live-in mates.

The holding environment provided by the family, whether it was overholding, ignoring, or pushing, did not appear to be related to whether or not a family remained in treatment. The only difference was with those few families who were already providing nearly ideal environments, of whom 90 percent completed and none withdrew from treatment.

Number of children, age position of identified child, age or sex of targeted child or oldest child, degree of difficulty of the child's problems or presence of special problems such as retardation, or a combination of difficulty of the child and presence of special problems, do not differentiate the families who withdrew from treatment from those who complete it.

The mothers were slightly younger in those families who withdrew from treatment, but not significantly. Education also made little difference with the exception that those mothers who completed college never withdrew from treatment. Mother's employment outside the home also had no bearing on treatment completion. Family earned income was lower for all families who did not complete treatment, but not significantly.

Based on information from about one-half of the women in the study, if the childhood of the mother was particularly negative, she was more likely to withdraw from treatment. If there were clear signs in the record that the mothers had a defensive attitude toward treatment, they were very likely to withdraw from treatment. Sixty-six percent of those coded for clear evidence of defensiveness actually withdrew from treatment. In looking at the interaction pattern between the mother and child, we find that if she was judged to have a lot to lose by changing, in terms of what she valued in her relationship with her child, she was more likely to withdraw. Over one-half of the 17 mothers whose possible loss was believed to be very great withdrew from treatment.

Mothers coded as at the imperial level of development were somewhat more likely to withdraw from treatment than interpersonal or institutional mothers, but just as many imperial mothers completed treatment as withdrew. Interpersonal mothers were more likely to complete (59 percent) than withdrew (27 percent) and institutional mothers were four times more likely to complete treatment (66 percent) than to terminate by withdrawing (16 percent).

The father's age, education, and employment status have no relation to treatment completion. However, if he was defensive regarding treatment or non-supportive of his wife, this family had a greater chance of withdrawing from treatment prematurely. If the mother and father were coded as having a close supportive relationship, 72 percent of them completed treatment; otherwise there appears to be little relationship between the parent's relationship and treatment completion.

We also examined some factors related to service provision and their relationship to whether or not a family completed the treatment process. If a family had received little or no prior treatment before coming to the agencies studied here, the family was more likely to withdraw from the current treatment program than a family with a history of professional help. This may have several implications. Possibly families who have previously sought help, but obviously not resolved the problem bringing them to the agency, may be more highly motivated. It is also possible that families with no record of prior attempts at help may not recognize their problems and be unwilling to invest themselves in a change process. For example, we have already noted that families referred by school personnel are somewhat less likely to make significant changes than others. Very possibly these are families who have been unaware of problems with their child and who are consequently threatened by such a referral rather than motivated by it.

Coders also rated the agency staff as to how well they met the parents' needs by being supportive of them. The less intensive the support of the staff was judged to be, the more likely the family was to withdraw from treatment. Those who completed treatment were judged to have received significantly more staff support. In addition, of those families who withdrew, one-third had little or no attempt made by the staff to address their adult problems and in only five percent did the staff make considerable effort to address their adult problems. In contrast, however, 62 percent of those who completed treatment had staff who in working with them made an effort to address their adult problems, not just their parenting problems. This is given added emphasis by the finding that the type of problem - whether only with child, or only adult, or a combination of the two - was unrelated to whether treatment was completed. Other evidence of the importance of dealing with adult problems is found in the analysis of the goals of treatment. While the individual goals coded did not discriminate as to treatment completion, families who withdrew had significantly fewer parenting goals as well as significantly fewer adult problem goals than those families who completed treatment. For both types of goals a ONEWAY Anova showed a significant difference at the .01 level. This could be a function of the fact that goals were coded throughout the length of service.

An examination of the problems the family brings to treatment, as coded from the records, indicates a few which stand out as indicating a difference between those families who withdrew from treatment early and those who completed treatment. Neither the type of adult problem coded nor the number of adult problems coded is indicative of early withdrawal. In terms of parenting problems, parents who had a lack of understanding of their children's abilities or limitations or had too high expectations of them, were more likely to withdraw from treatment. Interestingly enough, parents who had a problem, according to staff, with their philosophy of parenting or beliefs about parenting were much more likely to complete treatment than those who were not coded this way. Perhaps already having a thought-out philosophy is indicative of a parent's receptiveness to the possibility of reconsidering it. Ninety percent of parents coded as only having to learn child management techniques and not having other parenting problems completed treatment.

## THE GOALS OF TREATMENT AS EVIDENCE OF METHODS USED

### Goals for the Parents

In the records of each agency the plans for working with a family were stated in terms of goals, primarily for the parents as they were perceived to be the primary agent for change in each family. Although the initial code used to describe the goals was based on the HCT records, it was useful for analyzing records of the other three groups with relatively little modification. The goals were generally grouped and listed under broad categories, but since they were fairly specifically stated in the record, we used a very detailed code consisting of some 70 statements. However, this is obviously more detail than can be handled efficiently in any statistical analysis, so these specific codes were grouped in the categories listed in Table 19. Within each of these groups, a family is simply counted once even if this particular goal has been stated in several different ways. This happened most frequently in regard to certain of the child management goals. For example, "learn positive or encouraging child management techniques, or develop specific reward program" would include not only "learn to praise" but "learn to reflect feelings," and "foreshadow events."

These goals can be grouped further in the groups shown in Table 20. Two of these major groups deal primarily with interaction with the child, i.e., learning child management techniques, and improving interaction with the child. Didactic training also pertained to learning principles of behavior change and understanding child development. Improving functioning in the parenting role, however, dealt primarily with the parents' understanding of this role and being able to function within it rather than interaction with the child, while parents' problems dealt entirely with problems of their own adult life quite apart from interaction with their children. Within each of these groups of goals a sum of the individually mentioned goals was created, thus giving some indication of the extent to which problems in this area were important for a particular family. Some specific goals may, of course, be much more important than others in terms of what needs to be changed, but there was no consistent evidence of this. Generally, the goals of treatment were stated early in a record, but often other goals were added during the course of treatment. These, too, were coded and included in the total.

It seemed worthwhile to analyze the kinds of goals stated in the records as carefully as possible to see if these have any relationship with the overall outcome of the intervention.

An inspection of Table 20, which shows the relative frequency of specific goals within each of these general categories, suggests that there are significant differences among the agencies. In general, these differences are consistent with our understanding of the way in which each agency functions. For example, FCS, serving families with older children than are found in HCT and OPT families, used significantly fewer child management techniques than HCT and FTP. HCT also used significantly more than any of the other three agencies while FTP also surpassed OPT in their use. In regard to the various goals of interaction with the child, the average number of goals in this area for FCS were significantly higher than those for HCT or OPT. In the area of goals having to do only with parent problems, on the other hand, HCT had a significantly larger average number than OPT, but did not differ from the other agencies.

A parent goal total was based on the number of specific goals coded for each family. The OPT families had a significantly smaller average total than any of the other three agencies. This is not surprising in view of the much shorter period of treatment anticipated for OPT families and the consequent emphasis on fewer goals.

In a later section the contribution of these goals to outcome measures will be described.

It is to be noted that the goals used by each of these agencies were always developed, clarified, and agreed upon with the family members. In this respect it would seem that the methods used differ somewhat from Goal Attainment Scaling. In Reid and Epstein's terms (1972), these goals could be regarded as task achievement goals.

## Table 19

### Proportion of Families in Each Agency for Whom Various Goals for Parents Were Stated

| | HCT | FCS | FTP | OPT | TOTAL |
|---|---|---|---|---|---|
| No parents goals coded[a] | 1% | 16% | 5% | 3% | 6% |
| Learn child management techniques | | | | | |
| Learn positive or encouraging child management techniques, including reward program | 95 | 56 | 95 | 81 | |
| Learn interruptive child management techniques | 84 | 42 | 90 | 69 | |
| Learn principles of contingency management | 66 | Missing[b] | 35 | Missing | |
| Learn to provide structure for child | 47 | 58 | 50 | 28 | |
| Provide didactic training | 66 | 71 | 90 | 65 | |
| Help parents improve interaction with child | | | | | |
| Learn to be consistent with child | 34 | 49 | 25 | Missing | |
| Help child with specific needs (social-emotional, speech, etc.) | 29 | 40 | 65 | Missing | |
| Improve interaction with child (provide more family activities, play games, talk with child) | 56 | 58 | 60 | 50 | |
| Provide stimulation for development of cognitive skills | Missing | 2 | 15 | 28 | |
| Encourage child's autonomy independence | 20 | 22 | Missing | 22 | |
| Improve functioning in parenting role | 16 | Missing | 55 | 28 | |
| Work to resolve own problems of parent | | | | | |
| Learn problem solving skills | 39 | Missing | 5 | Missing | |
| Learn to express feelings, assert self, improve communication within family | 34 | 1125 | 25 | Missing | |
| Improve relationship with spouse (mate) | 24 | 38 | 30 | 9 | |
| Improve relationship with others | 16 | 7 | Missing | 9 | |
| Decrease undesirable behaviors | Missing | Missing | 20 | 28 | |
| Increase self confidence | Missing | 13 | 15 | 25 | |
| Set aside time for self/other | 13 | 13 | 20 | 6 | |
| Work closely and cooperate with school | 39 | 36 | 20 | 22 | |
| Number of families | 70 | 45 | 20 | 32 | |

---

[a] In general, these figures describe the families who declined to participate in treatment so early in the process that no goals were listed for them.

[b] This means that this particular code was not used for analyzing the data from the particular agency.

## Table 20

## Frequency of Specific Goals Stated for Each of the More General Categories of Parent Goals

| | HCT | FCS | FTP | OPT | TOTAL |
|---|---|---|---|---|---|
| No parents goals coded | 1% | 16% | 5% | 3% | 6% |
| Learn specific child management techniques | | | | | |
| No goals within this group rated | -- | 22[a] | -- | 3[a] | 7[a] |
| 1-2 goals | 4[a] | 33 | 20[a] | 44 | 22 |
| 3-4 goals | 16 | 29 | 35 | 41 | 26 |
| 5-8 goals | 58 | -- | 30 | 6 | 28 |
| 9-11 goals | 21 | -- | 10 | 3 | 11 |
| | 100% | 100% | 100% | 100% | 100% |
| Improve parents interaction with child | | | | | |
| No goals within this group stated | 19 | 4 | 10 | 19 | 14 |
| 1 goal | 40 | 24 | 25 | 53 | 38 |
| 2 goals | 24 | 29 | 30 | 22 | 26 |
| 3-4 goals | 16 | 27 | 30 | 3 | 16 |
| | 100% | 100% | 100% | 100% | 100% |
| Resolve parents' own problems | | | | | |
| No goals within this group stated | 27 | 20 | 45 | 48 | 32 |
| 1 goal | 27 | 36 | 15 | 29 | 28 |
| 2 goals | 25 | 20 | 20 | 17 | 21 |
| 3-5 goals | 20 | 9 | 15 | 3 | 13 |
| | 100% | 100% | 100% | 100% | 100% |
| Total number of parent goals coded | | | | | |
| 1-3 goals | 7 | 9 | 5 | 25 | |
| 4-5 goals | 17 | 18 | 5 | 50 | |
| 6-7 goals | 33 | 24 | 45 | 22 | |
| 8-9 goals | 29 | 31 | 25 | -- | |
| 10-13 goals | 13 | 2 | 15 | -- | |
| | 100% | 100% | 100% | 100% | |
| Number of families | 70 | 45 | 20 | 32 | 167 |

[a] When the proportion of families for whom no parent goals were stated are included, the percentages add to 100 percent.

## Goals for the Child

Only two agencies, HCT and FCS, regularly stated goals for the child, that is, changes to be worked for in the child's behavior. These also were coded first in very specific terms, using approximately 65 separate statements, and then grouped in much the same areas in which the early problems of the child had been coded (Table 21). However, because of the distinction made between increasing positive aspects of behavior or conduct, and decreasing or eliminating negative behaviors, both of these categories were used.

Just as in the case of the goals for parents, the child goals were added in each of these major categories to produce a total number of goals for each of the broad groups shown in Table 22. Although there are some differences between HCT and FCS families, none of these differences reaches a criterion of statistical significance.

## Table 21

### Proportions of Families for Whom Various Goals for Children Were Stated

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| No goals for child stated in records | 21% | 18% | 100% | 100% |
| Improve social interaction skills | | | | |
| Learn to control impulses | 10% | 22% | | |
| Learn to play independently | 33% | Missing | | |
| Learn to play cooperatively or otherwise age appropriately | 41% | 36% | | |
| Learn positive ways to obtain attention | 3% | 20% | | |
| Increase involvement with peer | Missing | 29% | | |
| Improve social interaction with others | 26% | 31% | | |
| Learn to comply, accept limits, improve behavior | 56% | 49% | | |
| Decrease undesirable behaviors | | | | |
| Decrease or eliminate aggressive behaviors, expressions of hostility | 29% | 22% | | |
| Decrease temper tantrums | 19% | 38% | | |
| Decrease coercive behavior | 30% | 13% | | |
| Decrease or eliminate specific problem behavior (fire setting, lying, stealing) | 23% | 33% | | |
| Decrease negative attention behavior | 27% | Missing | | |
| Improve emotional adjustment | | | | |
| Learn to express or accept feelings | 30% | 29% | | |
| Learn alternative ways of coping with frustrations, anger, depression | 10% | 11% | | |
| Develop autonomy, individuality, independent functioning | 4% | 9% | | |
| Improve relationship with others | 3% | 4% | | |
| Improve emotional adjustment in other ways | 9% | 16% | | |
| Improve academic functioning | 20% | 62% | | |
| Learn problem solving approach | 16% | Missing | | |
| Increase self confidence | 13% | 36% | | |
| Develop better communication with other | 39% | 22% | | |
| Develop or improve gross or fine motor skills | 11% | 13% | | |
| Develop age appropriate self-help skills, including toileting | 27% | 60% | | |
| Number of families | 70 | 45 | | |

## Table 22

### Frequency of Mention of Specific Goals in Various Categories

| | HCT | FCS | FTP | OPT |
|---|---|---|---|---|
| No goals for child stated in record | 21% | 18% | 100% | 100% |
| Improve social interaction | | | | |
| No goals in this category | 20% | 20% | | |
| 1 - 2 goals | 44% | 36% | | |
| 3 - 4 goals | 38% | 27% | | |
| Decrease undesirable behaviors | | | | |
| No goals in this category | 21% | 24% | | |
| 1 - 2 goals | 39% | 42% | | |
| 3 - 4 goals | 19% | 16% | | |
| Improve emotional adjustment | | | | |
| No goals in this category | 40% | 38% | | |
| 1 - 2 goals | 36% | 38% | | |
| 3 - 4 goals | 3% | 7% | | |
| Total number of groups in which goals for the child were coded | | | | |
| No goals for the child stated | 21% | 18% | | |
| 1 - 3 general categories of goals | 11% | 16% | | |
| 4 - 6 general categories of goals | 37% | 18% | | |
| 7 - 9 general categories of goals | 21% | 33% | | |
| 10 - 15 general categories of goals | 10% | 15% | | |
| Number of families | 70 | 45 | | |

# CHAPTER V
# EVALUATING THE EFFECTIVENESS OF THE INTERVENTION

In any study of the effectiveness of treatment and intervention, the measures used for this evaluation are most crucial of all. This is the dependent variable - the criterion in terms of which all of the other information will be examined in order to find which kinds of families seem to respond most favorably to the methods used. Obviously, if this measure is inadequate or contains serious errors, many of the findings could be questioned.

There is widespread recognition in the child welfare field that more satisfactory measures of outcome are needed. After reviewing the kinds of measures typically used by child welfare agencies to measure case outcomes, Magura and Moses (1980) also reached this conclusion. They suggested that any outcome evaluation "must focus on observable improvement (or prevention of deterioration) in a child's personal functioning and in his/her normal, permanent nurturing environment" (602). They conclude by indicating a preference for direct feedback from the clients. Although this is one way of obtaining evidence that cannot be considered biased by the worker's own point of view, it also seems to us to be limited in a number of ways. One reason for doubt is based on the OPT experience. An attempt was made to obtain such information from parents (primarily the mothers), through interviews conducted at the end of treatment and six months later. The mother's enthusiasm about the work of the team with them, expressed at these two times, was a poor indicator of the extent to which the team believed the family had made changes and improved their functioning.

Because of the complexities of family functioning and the apparent impossibility of developing a single measure that could be expected to describe change adequately in such functioning, we used a variety of methods. They are summarized in Table 23, in which the sources of the evaluation are also described. Research staff ratings were made of data from all agencies except FCS. In the few instances in which both kinds of ratings exist, their relationship will be reported.

Table 23

Techniques and Sources of Evaluation of Change in Families

| Techniques of Evaluation used | Source of Evaluation | Agencies for Which Information is Available |
|---|---|---|
| Judgment of extent of change in interaction within family, and of more specific aspects of interaction judged important in appraisal of treatment | Coder ratings | HCT, FTP, OPT |
| | Agency staff ratings | FCS, OPT |
| | Coder judgment of agency staff evaluation | HCT, OPT |

Table 23 (concluded)

| | | |
|---|---|---|
| Judgment of change in child's behavior and adjustment | Coder ratings<br>Agency staff ratings<br>Psychiatrist's evaluation | HCT, FTP, OPT<br>FCS<br>HCT |
| Attainment of specific goals of treatment for parents | Coder ratings<br>Agency staff ratings | HCT, FTP<br>FCS, OPT |
| Attainment of specific goals of treatment for child | Coder ratings<br>Agency staff ratings | HCT, FTP<br>FCS |
| Judgment of change in the holding environment and in the "core problems" of the primary family | Coder ratings<br>Agency staff ratings | HCT, FTP, OPT<br>FCS |
| Ratings on Family Rating Scale, evaluating status of family in regard to level of physical, cognitive, emotional care and extent of socialization at beginning and end of treatment | Agency staff ratings<br>Coder ratings based on records | OPT<br>FTP |
| Follow-up information regarding status of family and child after end of treatment | Family's reports and/or staff's evaluation | HCT, OPT |
| Follow-up information regarding removal of child from home or continuation of child in out-of-home placement | Agency staff reports<br>Follow-up contacts with family and supervising worker | HCT, FCS, FTP<br>OPT |
| Comparable observations of interaction in family prior to and at end of intervention | Staff analysis of observational data | OPT |

## JUDGMENTS OF EXTENT OF CHANGE WITHIN THE FAMILY AS A RESULT OF INTERVENTION

### Development of Parent Change Score

Since all of the families were referred because of problems in parent-child interaction, we reasoned that for any treatment to be judged as even partially successful, there would have to be evidence of improvement in this interaction, which generally required a change in the parent's behavior toward the child. In general also, it would be expected that such a change would produce some improvement in the child's behavior. As a result of this thinking, along with careful consideration of some of the more specific aspects of parenting behavior that would need to change in order to bring about improvement in the interaction, a number of specific codes were developed, each in an ordinal scale. This is a scale in which the relative positions of the four or five code numbers used are defined and represent a scale, but there is no assumption as to the extent of difference between one or another position. Ratings on the following scales were made by the coders.

1. Did treatment meet the child's need for nurturance or support or confirmation?

2. Did treatment meet the child's need to demonstrate competency or self-sufficiency when appropriate to the child's level of development?

3. At the end of treatment, is the parent praising more?

4. At the end of treatment, is the parent providing more structure for the child?

5. To what extent has overall interaction with the child improved since the beginning of work with the family?

Each of the more specific aspects of interaction described in the first four items is regarded as a primary requirement of adequate parenting. Every child needs to be nurtured or loved, appreciated, made to feel secure. Every child beyond the impulsive level of development needs opportunities to demonstrate competency or self-sufficiency. Every child needs positive feedback or praise for desirable behavior. Each child also needs some structure to daily living, which means at a minimum of routine of daily living in the home, including meals that can be counted on, regular bedtime, etc. The overall rating of the extent to which the parent's interaction with the child improved was a more general attempt to evaluate the effect of all of the intervention provided.

The intercorrelations among these measures was sufficiently high that it was possible to combine them into an average outcome score (Table 24).[5] We will refer to this as the Parent Change Score.

The intercorrelations among these measures were examined for each set of data first, then combined for all four sets. Since the coding of the FCS data had been done by staff members who had also been involved in work with families, this set of data was examined separately and contrasted with that describing the other three agencies combined. Only minimal differences were observed between these matrices, however.

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[5] Because of the extent of missing data in some of these more specific ratings, mainly because they were not applicable to some cases (as, for example, young children who could not be rated on the opportunities for competency, or others for whom praise, or nurturance, or structure were not a specific problem requiring change), the computer program available for computing a reliability coefficient (Cronbach's alpha) could not be appropriately used. However, for a matrix of correlations of this magnitude, there is little question that the reliability of the Parent Change Score is at .80 or higher.

Table 24

Intercorrelations of Ratings Combined to Produce
Parent Change Score

Data for All Four Agencies Combined

| | Change in interaction with child | Change in praise given to child | Change in structure provided | Change in nurturance provider | Change in opportunities for child to show competence | Parent Change Score |
|---|---|---|---|---|---|---|
| Change in interaction with child | -- | .807 | .824 | .826 | .574 | .878 |
| Change in praise given to child | | -- | .753 | .725 | .461 | .812 |
| Change in structure provided | | | -- | .705 | .528 | .834 |
| Change in nurturance provided | | | | -- | .625 | .790 |
| Change in opportunities for child to show competence | | | | | -- | .675 |
| Parent Change Score | | | | | | -- |

As evident in Table 24, the intercorrelations among these more specific ratings are uniformly high, with one exception. The correlations of the variable describing the "provision of opportunities to demonstrate competence" with each of the other variables is much lower than any others in the matrix. This suggests that this is an aspect of intervention that is often neglected by staff in work with families. Our interest on it stems from Kegan's (1982) developmental theory and the importance to the transitional or imperial child of such opportunities to demonstrate competence and self-sufficiency. In fact, once we became familiar with Kegan's theory and were sensitive to the needs of the transitional or imperial child to demonstrate competence, we noted instances in which attention to this need would have seemed particularly helpful to the child and possibly might have made a positive outcome more likely.

When the distributions of the Parent Change Scores were examined for the four agencies, it was apparent that the entire set of ratings for FCS families appeared to be less favorable than those for the other three groups. The difference between the FCS and HCT ratings of change in interaction was significant at the .01 level. We are not sure whether this represents a valid difference or whether it is primarily attributable to the different sources of the ratings, which were judgments made by FCS staff of their own work and by research staff coders of the work of the other three agencies. Possibly the FCS staff was more modest in assessing their effectiveness with the families. It is also possible that it is related to the kinds of families this agency dealt with -- primarily families with handicapped children/youth older than the relatively non-handicapped children in the HCT families. Trying to bring about change in a family that has a longer-established pattern of interaction with such a child might well be a more difficult and less-likely-to-be-successful task.

Another issue of importance is that the overall goals of the four agencies varied, particularly in regard to the philosophy of each regarding the relative importance of teaching child management techniques versus family counseling or addressing parenting problems, and the length of time of possible service. Another basis for difference was a response to the types of families served, with FTP exemplifying the extreme of attempting to reduce abuse or neglect by parents through the use of these methods, and FCS attempting to improve the functioning of mostly middle class families with a handicapped or disturbed child.

Regardless of the underlying reasons, however, we needed to cope with differences among agencies if the data were to be combined into one data set. Therefore, these ratings on Parent Change Score were converted to standard scores for each agency. This makes it possible to examine the correlates of "more successful" outcome with "less successful" outcome across all four groups.

It is also important to note that our objective in this study is not to compare the work of one agency with that of another except insofar as outstanding differences in clients or methods can increase our understanding of outcome. There are too many unknowns in the practice field and in our data to permit any precise comparisons of agencies in terms of outcome that could be considered reliable or valid or meaningful.

## Development of Child Change Score

Since the ultimate goal of treatment in these families is to help the parents improve their parenting in order to help the child, an indication of improvement in the child's actual functioning and behavior could be considered the preferable measure of effectiveness of the intervention. But this, of course, raises the question of how much improvement is necessary for intervention to be considered "successful," or even a more fundamental question of how the child's response can be assessed.

Two ratings of changes in the child's behavior were made in answer to the following questions:

1. Is there evidence that the child's actual behavior at home has improved since the beginning of treatment?

2. Is there evidence that the child's behavior in school has improved since the beginning of treatment-

Answers to both these questions were rated on a four point scale ranging from evidence of "substantial improvement" to "no improvement," with a rating of five given to a child whose behavior was judged to have worsened.

These ratings were averaged to provide a measure called Child Change Score. This also was converted to a standardized score for use in computations involving data from more than one agency.

Since information regarding the child's behavior in school was not generally available in either the FTP or OPT records, the ratings on only the first question provided this measure of improvement in the child from these two agencies.

An additional bit of evidence contributing to the evaluation of change in the child is available for 33 children or 47 percent of the 70 children in the HCT families worked with. A consulting psychiatrist typically sees a family and the child(ren) at the beginning and end of treatment, also providing consultation throughout the process, with additional contacts with the family and child if deemed necessary. His final report generally contained an evaluation of the progress (if any) made by the child in treatment, along with a careful assessment of the individual problems initially shown by the parents and the impact of the intervention on them. A rating of his final evaluation of the child's progress was made on a four point scare, ranging from "significant improvement" to "no improvement." His rating shows a correlation of .82 with the coder's rating of improvement in the child's behavior in the home, and of .90 with the rating of the child's behavior in school. These findings suggest that the evidence in the records was consistent regarding any changes in the child although this particular rating made by the psychiatrist is based on less than half the HCT clients.

## EXTENT TO WHICH THE SPECIFIC GOALS WERE JUDGED TO HAVE BEEN ATTAINED

An attempt was also made to rate the degree to which each of the specific goals for the parent(s) and for the child(ren) had been attained. This rating was based on a four point scale ranging from "goal fully achieved" to "no progress made." Such a rating could not always be made but information was available for ratings of approximately three-fourths of all the goals. These ratings were then grouped, just as the goals were grouped in broader categories, as described in Chapter IV, and averaged for each of these groups. An overall average also was created by averaging the ratings for all the goals. Obviously, this method has limitations in that some goals were much broader than others, but it seemed likely to provide a rough estimate of the relative effectiveness of the intervention. It also could be considered as providing some validating evidence for the other ratings made, particularly since the evaluation of the specific goals was made at a completely different time for the HCT data, at a different stage of the coding for the FCS data, and for the OPT data was based on the evaluation stated in the final questionnaire completed by the team that worked with each family.

The overall average for parent goals is called Parent Goal Outcome and that for the child's goals is called Child Goal Outcome. In the analysis of the relationship between outcome measures and characteristics of the families and child, specific outcome categories can be examined as well as the overall outcome. Undoubtedly, much more work could be done to take full advantage of the amount of detail available for study. However, there are limitations in the use of more specific outcome categories in that they represent smaller proportions of clients -- only those for who the specific kinds of goals were stated. As is apparent in Table 19, considerably fewer than half the parents had goals in half of the categories.

## USE OF CHANGE SCORES AND GOAL OUTCOME AS MAIN OUTCOME MEASURES

The four scores described in the preceding sections are regarded as the main indications of outcome of the intervention. Although each is based on different kinds of judgment, with goal outcome coded at a completely different time for the HCT and OPT data, provides additional evidence of their reliability and validity (Table 25). It is of interest to note that the relative attainment of goals for the parents is more highly related to the other measure of parent change than the relative attainment of goals for the child. And a similar relationship, although not marked, hold for the relationship of the measure of child change with attainment of the goals for the child as contrasted with those for the parent.

Table 25

Intercorrelations Among Outcome Measures for Total Sample

| | Parent Change Score | Child Change Score | Parent Goal Outcome | Child Goal Outcome |
|---|---|---|---|---|
| Parent Change Score | -- | .772 | .762 | .603 |
| Child Change Score | | -- | .614 | .649 |
| Parent Goal Outcome | | | -- | .804 |
| Child Goal Outcome | | | | -- |
| Number of cases | 161 | 144 | 135 | 103 |

## CHANGES IN THE HOLDING ENVIRONMENT PROVIDED THE CHILD AND IN THE "CORE PROBLEMS" OF THE PRIMARY PARENT

### The Characteristics of the Holding Environment and Changes Occurring

In Chapter III Kegan's (1982) developmental theory has been described briefly, including both the concept of developmental levels of the primary parent and of the child, as well as that of the holding environment. In addition to describing the holding environment as Overholding, Underholding-ignoring, Underholding-pushing, or Nearly Ideal, the coder was asked to document in detail the reasons for this by answering the following question:

> "What does the holding environment look like?"

Three characteristics could be coded in order to provide a description of the outstanding characteristics of the environment. It is evident in the data reported in Table 26 that there are differences among the three holding environments in the relative frequency of mention of many of the items. In some cases, the specific codes are similar to the overall description. The parents are characterized primarily in the following ways:

Those providing an overholding environment:
- Do not expect enough from the child
- Are not firm, consistent, do not provide follow-through
- Attend to child most of the time
- Fail to provide sufficient structure

Those providing an ignoring environment:
- Are most of all lacking in firmness, consistency, follow-through
- Fail to praise
- Fail to provide sufficient structure

Those providing a pushing environment:
- Expect more from the child than the child is ready for
- Are lacking in firmness, consistency, follow-through (mainly consistency)
- Respond negatively to child's minor misbehaviors
- Fail to praise

## Table 26

### Characteristics of the Holding Environment

| Parent: | Environment Provided Child<br>Holding | <br>Ignoring | <br>Pushing | Total Group |
|---|---|---|---|---|
| A. Fails to praise | 12% | 39% | 30% | 29% |
| B. Fails to provide sufficient structure | 32 | 37 | 22 | 29 |
| C. Generally ignores child | 6 | 16 | 11 | 12 |
| D. Responds negatively to child's minor misbehaviors | 9 | 16 | 30 | 19 |
| E. Expects more from child than child is ready for | -- | -- | 35 | 8 |
| F. Does not expect enough from child | 65 | 15 | -- | 22 |
| G. Attends to child almost all of the time (both positive and negative behaviors) | 35 | 4 | 3 | 10 |
| H. Criticizes child often and fails to praise | -- | 14 | 22 | 14 |
| K. Threatens child with removal from home | -- | 6 | 8 | 5 |
| L. Physically punishes child | -- | 9 | 11 | 5 |
| M. Is not firm, is inconsistent, provides no follow-through | 47 | 55 | 32 | 45 |
| P. Attends to negative behaviors and may be reinforcing such behavior | 12 | 27 | 22 | 21 |
| Q. Praises, but insufficiently | 3 | 10 | 3 | 7 |
| R. Provides child too much assistance | 23 | 1 | 5 | 7 |
| S. Is impatient, has negative attitude toward child | -- | 10 | 11 | 7 |
| T. Gives highly emotional directives | 21 | 11 | 24 | 16 |
| V. Is inconsistent in relating to child, sometimes treating child as peer | -- | 4 | 5 | 3 |
| W. Gives sibling conspicuously more attention | 3 | 1 | -- | 2 |
| | a | a | a | a |
| Number of families | 34 | 80 | 37 | 167 |

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[a] Percentages add to more than 100% because up to three characteristics could be coded.

After reading the entire record, the coder was asked to answer the following question:

> "What kind of an environment is the parent providing the child now, compared with pre-treatment?"

Approximately one-third of all the families worked with were judged to have made very little or no change in the environment provided their child, with another third judged to have made "some change," and slightly less than one-third to have made significant change by providing at least almost an ideal environment (Table 27). Whether the lower proportion of favorable change coded for the FCS families represents a valid difference or is related to the staff's modest assessment of their own work cannot be determined. The lower rate of significant change for the OPT families can most likely be attributed to the shorter period of work with them.

When characteristics of the holding environment were tabulated according to the degree of change rated (Table 28), a number of the specific problems show the same degree of change as that described in Table 27. The characteristics of the holding environment that seem most amenable to intervention are the parent's "attending to the negative behavior of the child" and "giving insufficient praise," although the latter is noted only for a small number of parents. The more general "failure to praise" (a more serious limitation than "insufficient praise") shows much the same change as the overall rating. The characteristics that seemed most resistive to change (such as "expecting more than the child is ready for," "threatening child with removal," or "inconsistency in relating to child") were each coded for relatively small numbers of parents.

Table 27

What Kind of Environment Is the Parent Providing the Child Now, Compared with Pre-treatment?

| | HCT | FCS | FTP | OPT | Total |
|---|---|---|---|---|---|
| Little or no change in holding environment | 32% | 33% | 25% | 34% | 32% |
| Some change but overall style is the same | 27 | 33 | 35 | 41 | 32 |
| Significant change; environment almost providing sufficient contradiction and confirmation | 29 | 9 | 35 | 16 | 22 |
| Significant change; now is ideal | 11 | 3 | -- | -- | 5 |
| Environment initially was almost ideal, now is | 1 | -- | -- | 6 | 2 |
| Not rated | -- | 22 | 5 | 3 | 7 |
| | 100% | 100% | 100% | 100% | 100% |
| Number of families | 70 | 45 | 20 | 32 | 167 |

Table 28

Changes Made in Holding Environment in Terms of Initial Characteristics of the Environment

| Initial characteristics of the holding environment | Little or None | Some | Significant | Significant, or almost ideal; now ideal | NA | Total | Number of Cases |
|---|---|---|---|---|---|---|---|
| A. Parent fails to praise | 33% | 38% | 25% | 2% | 2% | 100% | 48 |
| B. Parent fails to provide sufficient structure | 31 | 34 | 31 | 2 | 2 | 100 | 48 |
| C. Parent generally ignores child | 45 | 30 | 20 | 5 | 5 | 100 | 20 |
| D. Parent responds negatively to the child's minor misbehaviors | 28 | 22 | 28 | 9 | 13 | 100 | 32 |
| E. Parent expects more from child than child is ready for | 61 | 23 | 8 | 8 | -- | 100 | 13 |
| F. Parent does not expect enough from child | 33 | 47 | 14 | 3 | 3 | 100 | 36 |
| G. Parent attends to child almost all of the time | 29 | 30 | 29 | 12 | -- | 100 | 17 |
| H. Parent criticizes child often and fails to praise | 25 | 33 | 21 | -- | 21 | 100 | 24 |
| K. Parent threatens child with removal from home | 56 | 22 | 11 | -- | 11 | 100 | 9 |
| L. Parent physically punishes child | 50 | 30 | 20 | -- | -- | 100 | 10 |
| M. Not firm, inconsistent, no follow-through | 30 | 41 | 20 | 7 | 1 | 100 | 74 |
| N. Negative commands | 18 | 46 | 27 | -- | 9 | 100 | 11 |
| P. Attends to negative behavior | 28 | 23 | 43 | 3 | 3 | 100 | 35 |
| Q. Parent praises insufficiently | -- | 27 | 37 | 36 | -- | 100 | 11 |
| R. Parent provides child too much assistance | 46 | 27 | 18 | 9 | -- | 100 | 11 |
| S. Impatient, has negative attitude toward child | 58 | 17 | 17 | 8 | -- | 100 | 12 |
| T. Highly emotional directives | 18 | 59 | 23 | -- | -- | 100 | 17 |
| V. Inconsistent in relating to child | 80 | 20 | -- | -- | -- | 100 | 5 |
| Number of Cases | 51 | 53 | 36 | 11 | 16 | | |

Table 29

Extent of Change Judged to Have Occurred in the Three Types of Holding Environment Provided the Child

| | | Underholding | |
|---|---|---|---|
| | Overholding | Ignoring | Pushing |
| Little or no change | 29% | 31% | 41% |
| Some change but overall style is the same | 32 | 37 | 32 |
| Significant change | 30 | 26 | 16 |
| Environment now ideal | 3 | 5 | 6 |
| Change not rated | 6 | 1 | 5 |
| | 100% | 100% | 100% |
| Number of families | 34 | 77 | 37 |

Also of interest is whether change was more readily brought about in one kind of holding environment. As is apparent from Table 29, somewhat more of the Underholding-pushing parents were judged to have made little or no change, as compared with the parents in the other two groups, but this difference is not statistically significant. In general, approximately one-third of the parents who were Overholding or Ignoring their children were judged to have made "little or no change," with another third making "some change" and another third judged to have made "significant change" or be providing an ideal environment. One conclusion to be drawn from this table is that it appears equally difficult to bring about change in the three different kinds of holding environments.

Those in the group rated as making "some change" continued to show limitations in responding to the child's developmental needs, but were thought to show some improvement in this respect. For example, a mother who was seriously Overholding her 8-year-old son was willing, by the end of the intervention, to permit him to ride his bicycle away from the yard and at least around the large block, and, at least at times, was telling him how pleased she was with his caring for a younger sister. But despite these improvements, she was still overholding him, failing to understand his need for opportunities to show his competence, and even at times scolding him when he attempted to do so.

## "Core Problems" of the Parent

The question "What must the parent change to make the holding environment more healthful?" was also asked of the coder. This seemed particularly important in thinking about intervention. Even if the limitations of the holding environment could be described, the crucial question pertained to the kind of change that would need to be introduced and made meaningful to the parent so that the holding environment could be improved, that is, made more appropriate to the needs of the child. These needed changes were called "core problems" because they seemed to underlie the parent's difficulties in providing an appropriate environment.

Because of evidence that the children/youth in the FCS families were somewhat different than those in the other three groups, the "core problems" (or changes needed) of the three holding environments have been tabulated separately for the FCS parents as compared to those in the other groups (Table 30). This, of course, means the number of cases on which these percentages are based is quite small. Any differences must be interpreted cautiously. However, many of the differences between the frequencies of core problems mentioned for FCS families as compared with those in the other three groups appear to be directly related to the kinds of children in the FCS families and the parents' attitudes both toward the disability of their child and of their own parenting role.

Differences in the core problems noted for the three kinds of holding environments are the following:

Overholding parents in HCT, FTP, and OPT families are described most frequently as being overly dependent on their child. This was patently clear in many of these families. The child was the center of the mother's life to such an extent that in her desire to meet every need of the child, she was failing to provide the limits, the contradictions in Kegan's terms, that were essential for the child's growth. Probably related to this focus of the parent were her feelings about her own ability, or a lack of confidence in herself mentioned next most frequently for the overholding mothers. These could well account for the mother's need for her child's attachment to her. Here was a way in which she could show that she was a good mother - a competent mother. Unfortunately, though, she was not aware that growth requires something other than "waiting on" a child. In one outstanding example in the case records, we found that such a mother had been referred to several sources for help with her young son, who provided the central (and only) focus for her lonely, apparently unhappy life. The staff tried valiantly to help her understand her son's need for limits, for consistent training - as well as the good physical care she was giving him - and when they found these efforts fruitless and the mother withdrawing from treatment, recommended that she be encouraged and helped to obtain employment. Since she was a reasonably capable person, this could conceivably provide another source of satisfaction that in time would lessen her need for such a complete focus on her child.

The overholding FCS parents, on the other hand, were described as having somewhat different basic problems, primarily in their philosophy or belief regarding both their role in parenting and what their child was about, and also in accepting their child's developmental delay. Some of these parents saw their role as trying to keep the child "happy," meeting every whim as well as they could, and failing to see that even a handicapped child needed some structure to life.

Ignoring parents in the HCT, FTP, and OPT groups are described primarily as lacking understanding of what children need. Most did not seem purposefully inattentive, but rather lacking in any awareness that their children needed to be "noticed," played with, talked with, trained, provided with interested attention on the part of the parent rather than, as in some cases, given an array of stuffed animals to play with. The small group of FCS parents in this group were described as having problems with their relationship with another (presumably a spouse) and also in their negative feelings for their child.

Parents who are described as pushing in HCT, FTP, and OPT are described primarily as lacking self-confidence and also as having a mistaken belief of what children are all about, implying that they are using their children to meet their own needs in some way. In contrast, the FCS parents who are pushing are described as primarily having problems in their relationship with another person, presumably the spouse.

It is of some interest to note that the only problem considered of equal importance to parents, regardless of the particular environment provided, is the mother's feeling about her own ability, or a lack of self-confidence. This would have a different "meaning" to mothers at each developmental level, however. For example, such imperial mothers would need help to feel more sure of themselves in the parenting role (perceive it as a way of showing competence) before they could be expected to attend to their children. The interpersonal mother, who may be expressing her lack of confidence in her attachment to her child (or her mother, in some cases) needs help in finding other ways of feeling adequate. The institutional mother lacking in self-confidence also needs help in finding other evidences of her adequacy and in seeing how she is trying to meet her own needs by pushing her child.

## To What Extent Are the "Core Problems" Amenable to Change?

The coder was asked to indicate whether any change had taken place in the core problems during the intervention, and, if so, the extent of change. Because there was so much missing data in the evaluation of the problems of the FCS parents, only the data describing the HCT, FTP, and OPT parents are shown in Table 31. Since the number of persons showing each type of core problem is relatively small, much caution must be used in examining these specific details.

In general, the problems least amenable to change by means of the kinds of intervention used by these agencies, are the parent's self-serving stance, negative feelings toward the child, and philosophy/belief structure of what the child is about. This latter was coded most frequently for imperial mothers, and would seem to be a mis-statement for them as at this level of development they do not have a belief structure as institutional mothers do. It is probably more correctly stated as "level of understanding of what this child is all about."

## Table 30

## Relationship Between Holding Environment and "Core Problems" of the Parent in Which Change Was Judged To Be Needed

| | Environment provided child | | | | | |
|---|---|---|---|---|---|---|
| | | | Underholding | | | |
| | Overholding | | Ignoring | | Pushing | |
| | Mentioned by | | Mentioned by | | Mentioned by | |
| What must the parent change to make the holding environment more healthful? (core problem)[a] | HCT<br>FTP<br>OPT | FCS | HCT<br>FTP<br>OPT | FCS | HCT<br>FTP<br>OPT | FCS |
| A. Parent's self-serving stance | 6% | -- | 14% | 22% | 20% | 14% |
| B. Parent's over-dependence on the child | 50 | 13 | -- | -- | 12 | 7 |
| C. Parent's relationship with another | 13 | 15 | 8 | 55 | 8 | 43 |
| D. Parent's philosophy/belief structure of what this child or children are about | 6 | 31 | 9 | 11 | 32 | 14 |
| E. Parent's philosophy/belief structure of parenting | 13 | 38 | 17 | 11 | 12 | 14 |
| F. Parent's negative feelings toward child | -- | -- | 14 | 44 | -- | 21 |
| G. Parent's feelings toward own ability | 31 | 25 | 29 | 22 | 40 | 14 |
| H. Parent's ideas of what children need | 25 | -- | 40 | -- | 24 | -- |
| I. Parent needs to make decision about commitment level to child | 19 | 13 | 22 | 33 | 8 | 21 |
| J. Parent's acceptance and understanding of child's developmental delay | 13 | 31 | 2 | -- | 12 | 21 |
| K. Parent needs to make decision about commitment to self | 25 | 6 | 19 | -- | 6 | -- |
| Y. Parent only needs to learn CMT skills | -- | 13 | 8 | -- | 12 | -- |
| Number of persons rated | 16 | 16 | 65 | 9 | 25 | 14 |

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[a] If two changes in core problems were coded, both are counted and included in the percentages. Hence the columns add to more than 100%.

Table 31

Extent of Change Made in "Core Problems" by Parents
in Three Groups, HCT, FTP, and OPT

| Of the parents described as having these "core problems": | Were judged to made made: Significant change | Some change | Little or no change | | Number of cases |
|---|---|---|---|---|---|
| A. Self-serving stance | -- | 13% | 87% | 100% | 15 |
| B. Over-dependence on child | 42% | 33 | 25 | 100% | 12 |
| C. Relationship with another | 33 | 45 | 22 | 100% | 9 |
| D. Philosophy/belief structure of what this child or children are about | 13 | 27 | 60 | 100% | 15 |
| E. Philosophy/belief structure about parenting | 24 | 47 | 29 | 100% | 17 |
| F. Negative feelings toward child | 10 | 20 | 70 | 100% | 10 |
| G. Feelings toward own ability | 13 | 42 | 45 | 100% | 38 |
| H. Ideas of what children need | 35 | 35 | 30 | 100% | 37 |
| I. Needs to made decision about commitment to child | 15 | 35 | 50 | 100% | 20 |
| J. Acceptance and understanding of child's developmental delay | 72 | 28 | -- | 100% | 7 |
| K. Needs to make decision about commitment to self | 22 | 39 | 39 | 100% | 18 |

It appears that the kinds of intervention used were effective in helping parents understand their children's needs, resolve some of their over-dependence on their children, and, for the small group with this difficulty, accept their child's developmental delay. Problem areas in which at least some change was judged to have occurred include the parent's philosophy/belief structure of parenting and relationship with another (presumably the spouse).

As might be expected, the mother's developmental level is significantly related to the extent of change she made in the core problems (an r of .41). This is only one of many kinds of evidence that the mothers at a higher developmental level are more responsive to the intervention attempted. Both judgments of the extent of change made in the environment provided the child and the change in the "core problems" show significant and high correlations with the primary measures of outcome and with other indications of the effectiveness of the intervention (Table 32).

### Table 32

### Relationship of Changes Made by Parents in Holding Environment Provided Child, Changes in "Core Problems," and Developmental Level With Other Indications of Outcome of the Intervention

| | Change in environment provided child | Change in "core problems" of parent | Developmental level of parent[a] |
|---|---|---|---|
| Parent change score | .780 | .705 | .553 |
| Interaction with child | .812 | .792 | .555 |
| Praise given to child | .736 | .730 | .413 |
| Structure provided | .754 | .742 | .316 |
| Nurturance provided | .801 | .709 | .603 |
| Opportunities for child to show competence | .524 | .390 | .310 |
| Child change score | .654 | .474 | .439 |
| Parent goal outcome | .731 | .713 | .457 |
| Child goal outcome | .640 | .507 | .452 |
| Did treatment last as long as staff believed appropriate | .545 | .442 | .241 |
| Level of defensiveness shown by mother | .549 | .539 | .456 |

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[a] This variable is available only for data from HCT, FTP, and OPT.

## PARENTS' ADULT OR NON-PARENTING PROBLEMS

Because it was evident in the records also that a number of the parents had problems in their own adult lives that were undoubtedly affecting their parenting and even, in some cases, their ability to focus on the problems with their children, a highly specific code was developed to describe these problems, two of which could be indicated for each person. They were then grouped in the following categories:

- -- problems in relationship or interaction with spouse
- -- problems in interaction or relationship with others, such as own parent or parents, or a former spouse with custody fears in some cases
- -- lack of support or friends; no involvements outside of home, lonely
- -- a focus on own needs, such as a search for identity
- -- difficulty coping with everyday problems
- -- financial problems, physical or health problems
- -- spouse's incapacity

Sixteen percent of all the parents were coded as having no conspicuous adult problems.

## Summary Descriptions of Parents' Problems

However, since there was too much information to use in detail except in a number of qualitative analyses, categories of problem areas were developed to take into account all of the information available in the description of the holding environment, the "core problems," and the parents' adult problems. The categories mentioned sufficiently frequently so that they could be used in statistical analysis are shown in Table 33.

Table 33

Summary of Parents' Problems

| | HCT | FCS | FTP | OPT | TOTAL |
|---|---|---|---|---|---|
| Problems in Adult Life | | | | | |
| Lack of self confidence or a positive self image | 43% | 22% | 50% | 50% | 36% |
| Relationship with current spouse or live-in mate | 27 | 7 | 15 | 46 | 24 |
| Immaturity; own needs take precedence | 36 | 27 | 35 | 41 | 34 |
| Relationship with former spouse or parents or others | 27 | 7 | 15 | 47 | 24 |
| Unemployment, money management | 17 | 7 | 10 | 28 | 16 |
| Lonely, with lack of friends or no involvements outside of home | 14 | 13 | 10 | 13 | 13 |
| No apparent adult problems | 19 | 11 | 20 | 16 | 16 |
| Problems in Relationship or Interaction with Child | | | | | |
| Lack of praise or positive attention to child | 66 | 33 | 95 | 46 | 57 |
| Lack of understanding or appreciation of child's abilities or training potential; magnifies problems or does not accept disability; has low expectations | 53 | 42 | 70 | 44 | 50 |
| Fails to set limits or structure | 41 | 49 | 30 | 19 | 38 |
| Attends to negative behavior | 47 | 42 | 5 | 19 | 35 |
| Is inconsistent | 44 | missing | 35 | 28 | 28 |
| Has dislike, negative feelings, or ambivalence for child | 21 | 24 | 25 | 22 | 23 |
| Disagrees with spouse in managing child | 16 | 9 | 30 | 9 | 14 |
| Has too high expectations of child(ren) | 16 | 13 | 15 | 13 | 14 |
| Only needs to learn child management techniques | 14 | 16 | 5 | 9 | 13 |
| Number of families | 70 | 45 | 20 | 32 | 167 |

These characteristics were first examined in terms of their relationship with the types of holding environment. Overholding parents are very likely to be lonely, particularly those in HCT, FTP, and OPT, which may be hypothesized to account, at least in a large part, for their over concentration on their child and their dependence on the child. The correlations of overholding with being lonely range from .55 to .66 for the three groups. Overholding parents also appear to be somewhat older, although this relationship is very modest. As indicated earlier, they are more likely to have handicapped children, with FCS mothers more likely to have a handicapped child than those in the other groups. Overholding mothers are not lacking in praise or attention to their children. Rather, the picture created by the examination of the various parent problems with overholding is of a generally permissive parent focusing on the child but failing to provide the structure and training needed by the child.

Ignoring parents are characterized as immature and as having poor interaction with their children, particularly in failing to praise and attending to negative behavior. They are not lonely.

Mothers who are described as pushing their children are primarily distinguished by their lack of understanding of the child, a variable in which lacking understanding is combined with having too high expectations of the child, which shows a correlation at the .45 level for HCT families and .27 for FCS.

## Significance of the Mother's Developmental Level

In Table 11 (Chapter III), the relationship between the mother's developmental level and the holding environment provided the child is shown, and in much of the discussion in the preceding sections, it is clear that the mother's developmental level is highly related to some of the problems she evidences as well as to her responsiveness to the intervention. In fact, it could be considered a capsule description which, perhaps more than any other variable, has direct implications for work with the family.

It has already been noted that the extent to which the mother made positive change in the environment provided the child is highly correlated with her developmental level (an r of .48). Changes in her "core problems" also are significantly related to her developmental level (r of .41).

Some of the summary categories of parents' problems shown in Table 33 are related to the mother's developmental level, particularly immaturity and relationship with own parent(s) or former spouse. The total number of adult problems is inversely related to developmental level, while the absence of any apparent adult problems is positively correlated with developmental level. There are less clear relationships of problems the parents have in interaction with their children and developmental level, although there is some indication that negative feelings for the child are inversely related to development level. The total number of problems in regard to their children is not related to developmental level. Nor are the types of goals -- either for the parents themselves or for the children -- related to developmental level.

## The Family Rating Scale

Early in the OPT project, a Family Rating Scale was developed in order to provide a basis for comparison of the status of the families at the beginning and end of work with them. There was need for a scale that would be pertinent to all families and would assess some of the basic dimensions of adequate child care. The few other scales developed for a similar purpose were found to include such highly specific items that they would not be equally appropriate for all families. The dangers in rating families on such broad dimensions were recognized but these could be at least in part mitigated by careful definition of the dimension and the scale points.

The Family Rating Scale provided for ratings on a continuous scale, with discrete points defined, for the following four dimensions[1]:

1. Life maintenance or physical nurturance, defined as the "extent to which the family has (provides) enough food, clothing, shelter, and hygiene or health care to sustain life at a healthy level," rated on a five-point scale ranging from the lowest rating described as "severely deficient in three or four areas" to the highest rating, defined as "not deficient in provision of these needs (continuously provides)."

2. Emotional nurturance of the child(ren) by the parent(s), defined as "extent to which the parents have warm positive interaction with each child and demonstrates recognition of the child's separateness and worth (individuality)," rated on a five point scale ranging from the lowest position of "no evidence of nurturance" to the highest rating, described as "high level of nurturance." If there appeared to be differences in the ways the children were treated, each child was rated separately, and if the two parents differed, they were rated separately.

3. Cognitive development of children defined as "extent to which a positive and stimulating environment is provided by the family for the children," rated on a five-point scale ranging from "not at all" to "great extent."

4. Socialization of children, defined as "extent to which an environment is provided for socializing the children at appropriate level for age and development," rated on a four-point scale ranging from "no evidence of such an environment" to "an adequate environment."

5. A rating of the "extent to which adults in the family support each other emotionally" was also included in the original scale used by OPT. Because of the large number of single mothers in this small set of data, however, this information has been used only qualitatively. We regard it as a very important dimension, however. It was duplicated in the code used for all of the agencies to describe the "relationship of the father and mother."

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[1] A copy of the form used appears in the Appendix along with detailed descriptions of criteria used for each position on the scale.

The OPT staff members first rated the families they were to work with after the completion of the initial interview and observations, and again (generally without consulting the initial ratings) after the end of their work with the family. In this current project, the OPT data have been used, and ratings were also made on the Family Rating Scale for the FTP families. Agency records are not completely satisfactory for such use, however, as there is likely to be insufficient information to provide a basis for some of the ratings. This was the reason for the early decision not to attempt to use the Scale on the HCT and FCS records. Since the FTP data more frequently contained information about Life Maintenance and Cognitive Stimulation, however, the decision was made to attempt the ratings for that group of families. The findings based on these two small groups should only be viewed as suggestive, however.

The care provided by the parents is significantly related to the Degree of difficulty of the child for all areas but Life Maintenance, with the Initial rating on socialization showing the highest correlation (.407) with Degree of difficulty of the child. The initial ratings on the scales of Emotional nurturance, Cognitive stimulation, and Socialization are significantly correlated with Parent Change Score, ranging from a low of .32 for Emotional nurturance to a high of .57 on Socialization (Table 34). This suggests that the parents responding best to the intervention are likely to be those who are aware of the importance of training their children and are fairly adequate initially in providing Socialization for their children.

Another way in which the data may be examined is by analysis of variance, testing the possibility of significant differences among outcome groups on both the initial and final ratings. This clarifies the observations that could be inferred from the size of the correlations. There are no significant differences among the four outcome groups (defined by "considerable, some, little, or no change in parent interaction with child") in the initial ratings on either Life Maintenance or Emotional Nurturance. Further, the four outcome groups show no significant change in ratings on any scale other than Emotional nurturance.

These findings suggest that the family's initial rating on degree of Cognitive stimulation and of Socialization have some predictive value in identifying the families most likely to respond to the kinds of intervention used, but that their initial ratings on the other two scales (Life maintenance and Emotional nurturance) are not of predictive value. Further, the one area in which significant change occurred during the intervention was in Emotional nurturance. This is not to say that some change did not occur in all four areas, but that it reaches the criterion of significance at the .01 level only in this one area.

Table 34

Relationship Between Ratings on the Family Rating Scale and Measures of the Outcome of the Intervention

| | Measures of Outcome | | | | |
|---|---|---|---|---|---|
| Initial ratings on Scale | Parent Change Score | Child Change Score | Parent Goal Outcome | Change in Environment Provided Child | Change in "core problems" |
| Life maintenance | .207 | .270 | .038 | .181 | .229 |
| Emotional nurturance | .319 | .305 | .200 | .334 | .357 |
| Cognitive stimulation | .434 | .527 | .282 | .347 | .418 |
| Socialization | .571 | .689 | .384 | .551 | .576 |
| Final ratings on Scale | | | | | |
| Life maintenance | .394 | .364 | .283 | .289 | .392 |
| Emotional nurturance | .659 | .675 | .524 | .610 | .603 |
| Cognitive stimulation | .631 | .650 | .501 | .541 | .599 |
| Socialization | .679 | .698 | .473 | .620 | .567 |
| Number of families | 51[a] | 41 | 30 | 50 | 51 |

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[a] These numbers show the families for which both sets of data were available. No correlations are shown for the Child goal outcome as child goals were not coded for FTP and are shown only for a limited number of OPT families.

## FOLLOW-UP INFORMATION

### Status of Family and Child after End of Intervention

Additional information is available regarding HCT and OPT families after the end of treatment. Regular follow-up was scheduled at six-month intervals with OPT families, and a questionnaire was given to the HCT staff requesting information regarding the status of the family. They had heard from approximately half the families worked with, but made attempts to reach others to find out how the family was getting along. As a result, there is some follow-up information available for 76 percent of the HCT families and 94 percent of the OPT families. This represents a period of six months or longer for all but 5 percent of the HCT families and 9 percent of the OPT families. In the case of a few HCT families, (11 percent of the total) the longest follow-up represented a period of over three years -- a length of time in which many other events could affect the status of the family and child. Consequently, we have omitted from Table 35 information that described a family after an interval longer than three years.

Table 35

Information from Two Agencies Regarding Status of Family and Child After the End of Treatment

| Judgment regarding status at follow-up as compared with that at the end of treatment | Status of Family | | Status of Child | |
|---|---|---|---|---|
| | HCT | OPT | HCT | OPT |
| Has improved | 37% | 30% | 33% | 43% |
| Has remained the same | 29 | 40 | 38 | 27 |
| Has deteriorated slightly | 7 | 10 | 2 | 7 |
| Has deteriorated considerably | 20 | 7 | 20 | 3 |
| Rating could not be made | 7 | 13 | 7 | 20 |
| | 100% | 100% | 100% | 100% |
| Number of families | 45 | 30 | 45 | 30 |

Judgments as to the status of the family and of the child were made by the coder, but based on the information in the record. They are expressed in terms of comparison with the status existing at the end of treatment. Substantiating evidence was required in order to code that the family or child had improved since the end of treatment. At least two-thirds of the families about whom follow-up information was available were judged either to have retained the status they had shown at the end of the intervention or to have improved (Table 35). That a third were judged to have improved since the the end of treatment provides some evidence of the value of the kinds of intervention used.

When the HCT records of the 20 percent whose status (both family and child) had deteriorated considerably were examined, we found that one family had moved away before the planned treatment had ended, while six had withdrawn without showing any improvement in their interaction with their child. Only two out of the nine families had stayed in treatment as long as the staff regarded desirable. Both of these were single fathers; one was thought to have made considerable progress in understanding the needs of his children but was unable to maintain this, in part at least because of the emotional and financial worries associated with this wife's incapacity.

## Removal of Children from Families

One criterion of the relative effectiveness of the work with families is whether the family remained intact. Information regarding removal of a child/youth from each family was requested from each agency, although the proportion of families about whom such information is available varies considerably from 53 percent of the FCS families to 94 percent in the OPT families (Table 36).

Removal of the child/youth, however, is an objective and appropriate indication of the effectiveness of the work with families, since one of the primary goals of the intervention was to preserve the family and enable the parents to provide sufficiently appropriate and adequate care so that their children could remain at home. If removal occurred, it would indicate that the goal of preserving the family was not attained.

Although it would appear that the fact of removal, or of a child's remaining in foster care is a very simple determination, there are complexities even in this. Since we expected to consider this a measure of effectiveness, we defined it in the following ways:

a. Children who were removed because in the judgment of an outside authority, the parent is unable to provide adequate care or supervision. In this category would be included the families whose children were in foster care at the time of intervention and who remained there because the agency did not regard the parents as having made sufficient change to warrant their return, and the family whose parental rights were terminated after a concentrated effort was made to help the parents improve their parenting.

b. Children who were removed or placed elsewhere by the parent or parenting figure because they did not want to care for them. This would include a mother who gave up her three young children for adoption or the OPT relative who, in returning the nephew she had been caring for since infancy to his own mother, indicated her unwillingness to continue to work with the child.

Several other instances of change, however, did not seem to fit the criterion of inadequate or inappropriate parenting. One was the case of the oldest son who decided to go live with his mother; he was a step-son of the single father caring for three step-children and one son. Another was the court's decision to transfer custody of a step-brother of the "targeted child" to his father rather than having him remain with his mother and step-father. However, this boy's care had seemed quite adequate and seemed unrelated to the work with the family regarding the younger child.

The source of the follow-up information also may produce some differences among agencies. For example, much of the follow-up information from the HCT families came directly from the families through contacts which they themselves sometimes initiated. It would be expected that families who were doing well would be more likely to initiate such a contact (unless they were seeking further help) than those who had not done so well or who had dropped out of treatment. When we tabulated the outcome of the intervention of the 77 percent of the HCT families for whom follow-up information was available, it was clear that a larger proportion of these had been rated as having a relatively good response to the intervention than of the total population served.

In the case of the FCS families, however, most of the information about removal came from the staff's contacts with the schools. Through this they would hear of the removal or replacement of some of the children/youth they had previously worked with. They also learned this through other professional contacts. Only in the case of OPT was there any attempt systematically to reach the families and learn what their current status was, and even for this group of families, there was less personal contact with those who had withdrawn from treatment than the other families. The FTP data came primarily from the Department of Social Services as well as from the FTP staff.

For both the FCS and FTP, the only information available was regarding the composition of the family -- whether the "targeted child" or all of the children were in the home or had been removed. As indicated in Table 36, such information was available regarding 72 percent of all the families worked with by these four agencies. All of the percentages shown in Table 36 are based on the total number of families served by each agency.

Data from both FCS and FTP a considerably larger proportion of children removed (or remaining out of) from the families worked with than HCT or OPT. In fact, removal had occurred in one-half of the families about which FCS or FTP had information, whereas it had occurred only in 13 to 16 percent of HCT and OPT families.

The most likely placement for a child who was removed was a foster home, followed by placement in an institution for emotionally disturbed children.

Among the characteristics of the families from which these children were removed are the following:

Slightly over half are single parent families.
Over half (56 percent) did not remain in treatment as long as the staff believed important, nearly equal proportions withdrawing or leaving for other reasons.
Seventy percent of the children removed were rated "very" or "extremely difficult."
The proportion of Handicapped children in the group removed is similar to that in the total sample.
Using the single outcome rating of "change in interaction of parent with child" as the measure of outcome, three-fourths of these families were judged to have made "little or no change."

## Observations of Interaction Within the Family

As noted in Table 1, each of the four agencies utilizes systematic observations of the family's interaction in order to obtain some understanding of the problems. One measure of outcome that would seem to offer greater objectivity than most would be repeated observations of the same type, preferably made by staff other than the team that worked with the family. This was utilized by OPT as part of its research design, but was not used by any of the other groups. Even in the OPT families, data were available just from 18 of the 32 families; consequently, any analysis of is primarily qualitative. It is particularly limited in that some of the 8 families that withdrew from treatment could be included, as final observations were not made in their homes.

## Table 36

### Information Regarding Removal of Children From Families Who Were Worked With by the Four Agencies

| | HCT | FCS | OPT | FTP | Total |
|---|---|---|---|---|---|
| Information available regarding interactions of family | 77% | 53% | 94% | 60% | 72% |
| Proportion of families from whom one or more children were removed during or after intervention | 13% | 27% | 16% | 30% | 19% |
| Children were removed to: | | | | | |
| foster home | 11% | 7% | 3% | 15% | 8% |
| foster home, with expectation of eventual adoptive placement | -- | -- | 3% | 5% | 1% |
| institution for emotionally disturbed | 1% | 14% | 7% | 5% | 6% |
| group home | -- | 2% | -- | 5% | 1% |
| other parent | 1% | 2% | -- | -- | 1% |
| own parent from relative's home | -- | -- | 3% | -- | 1% |
| not known (children kicked out by parent) | -- | 2% | -- | -- | 1% |
| Make-up of families from which children were removed: | | | | | |
| both biological parents in home | -- | 7% | -- | 15% | 3% |
| one parent and step-parent | 1% | 7% | 3% | 5% | 3% |
| single mother with live-in mate | 5% | -- | 10% | -- | 3% |
| single parent | 6% | 7% | -- | 10% | 6% |
| foster parents | 1% | 4% | -- | -- | 2% |
| adoptive parents | -- | 2% | -- | -- | 1% |
| relative of child | -- | -- | 3% | -- | 1% |
| Number of families | 70 | 45 | 32 | 20 | 167 |

Comparisons of the "before" and "after" observations were made primarily in terms of the frequency of (a) the use of praise or positive feedback and (b) the child's degree of compliance to clear directions, as these were the two child management methods that received the greatest emphasis from the teams in their work with the families. The results indicated that there was a slight increase in the use of praise by the end of treatment, although not sufficient to reach the .05 level of significance. It was unrelated to the relative rating of outcome, however.

When the child's compliance to clear directions was examined, no relationship with outcome was found in the initial rate of compliance, but a slight relationship was found in the final observations, suggesting that there was a probability of at least 80 percent that the children in the families rated as having made significant change in their interaction were more compliant than those in the families not rated this highly.

Because of the small number of cases involved, we have not attempted to use this information in any way in the analysis of data in this study. However, this method provides a more objective measure of interaction in the family than any other described here and is recommended for use. Even if families might attempt to do their best in a final observation, it seems unlikely that they could maintain a high level of positive interaction over the hour and a half of a typical observation period without giving some clues as to continuing problem areas.

111

# CHAPTER VI
# CAN THE OUTCOME OF INTERVENTION BE ACCOUNTED FOR?

In view of the large number of variables on which data were collected in this study, the decision as to how to examine the relationship of the independent variables with outcome was an important one. Although a number of factors played an important part in this decision, the primary one was the extent of missing data in the variables. Since 36 percent of the families had only a single parent in the home, and an additional 12 percent consisted of a single mother with a live-in mate, the extent of missing data describing fathers was so great that it was not feasible to use any information specifically describing fathers in the major regressions. This was also the case with income of the family. In addition, there were a number of variables for which there was no information from one or even several agencies. In any attempt to look at the data as a whole, these could not be used. Using such criteria, the list of variables diminished considerably but was still so extensive that it seemed reasonable to examine them in three separate sets, each described below.

In addition to examining the total set of data for all of the families in the four agencies studied, it also seemed important to look at some smaller subsets since there were substantial differences among the agencies in some of their characteristics. As has already been indicated, the data from FCS differed in a number of ways, not only because the families served by FCS far more frequently than others had a developmentally disabled child/youth, but also because the records were coded by the staff members who had worked with them. For this reason, we have looked at three agencies, HCT, FTP, and OPT, as one group, totaling 122 families, and have looked at FCS separately, although the limitation of the size of this group means statistically significant findings are less likely. In addition, we have analyzed the data for HCT families (numbering 70) as the data from this agency were by far the most detailed and carefully kept of any set, and contain less missing data on individual variables than any other set. The fact that the records were all typed made them much easier to work with than those of the OPT project, which had also been kept carefully, with a few exceptions, but were for the most part handwritten. Because of the prevalence of one parent families, totaling 81, or 48 percent of the total group, when the single mothers with live-in mates were included, it was also important to examine possible differences between the outcomes of one parent as compared with two parent families. Hence, the variety of groups shown in each of the tables in this chapter.

We realize that the size of some of the subgroups is very small for the use of multiple regression analysis. However, our main findings and discussions are not based on the results of the equations of these subgroups, which are examined for possible similarities and differences in relationships. Stepwise regression was the statistical method used to determine the relative contribution of the independent variables in the regressions of the outcome scores. Admittedly, this technique may enhance the proportion of explained variance, but in the absence of a model or underlying hypotheses, this technique seemed preferable. In each equation, the independent variable that explains more of the variance than any of the others will enter first, followed by others in the order in which they contribute to the variance. In every table, the proportion of explained variance has been adjusted for the number of variables entering the equation, so it is always somewhat smaller than the $R^2$.

## RELATIONSHIP OF CHARACTERISTICS OF FAMILIES AND CHILD AT TIME OF INTAKE WITH OUTCOME

The first characteristics to be examined were those that would be most readily available at the time of intake, namely the socioeconomic and demographic characteristics of the family and of the targeted child. Those selected included the following:

1. Mother's educational level, which was correlated highly with the father's educational level and, unlike that of the father, was available for most of the families.

2. One or two parent family. This was based on the information about the family constellation, originally a detailed code but modified to consist of just two categories -- homes with two parents and homes with a single parent. There are six single fathers included in the single parent group. The 12 percent of families with a single mother and a live-in mate were categorized as one parent families. For the most part, these men were not involved in either child care in the family or the treatment process.

3. Reason for referral. The original reasons were grouped in the following ways to give an indication of relative emphasis on the parent's lack of skill as compared with characteristics of the child which would not generally imply a criticism of the parent.

    a. Behavioral problems of child or difficulties associated with child's developmental delay. Difficulties can be attributed to child's behavior or child's problems.

    b. Parents' difficulty in managing the child, or alleged possible abuse or neglect of child, or plan to return child from foster care.

    c. Child's behavior in school, or differences between parents and school regarding child. This is a referral coming from outside the family, implying criticism of the parents; further, the parents may be unaware of the child's behavior in school so that this is the first indication to them that someone views their child as a "problem."

4. Prior social services treatment experienced by the family, as described in Chapter III.

5. Degree of difficulty presented by the child's behavior, a rating described in Chapter III.

## Table 37

### Regression of Parent Change Score on Independent Variables Describing Characteristics of Family and Child That Could Be Determined at Intake

| Group | Number of Families | Significant Independent Variables | Proportion of Explained Variance[a] | F value |
|---|---|---|---|---|
| Total | 162[b] | 1. Problems of family mainly child, adult or both<br>2. Mother's education | .126 | 11.03<br>(.000)[c] |
| HCT<br>FTP<br>OPT | 122 | 1. Mother's education<br>2. Problems of family mainly child, adult or both | .157 | 10.296<br>(.000) |
| HCT | 69 | Problems of family mainly child, adult or both | .194 | 14.446<br>(.000) |
| FCS | 40 | Problems of family mainly child, adult or both | .079 | 4.118<br>(.050) |
| Two-parent families[d] | 79 | 1. Mother's education<br>2. Problems of family mainly child, adult or both | .134 | 5.797<br>(.005) |
| One-parent families | 80 | Problems of family mainly child, adult or both | .135 | 12.443<br>(.001) |

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[a] This figure, the $R^2$, is always adjusted for the number of variables entering the equation.

[b] When Outcome is considered, five families who received no intervention were omitted. This accounts for the decrease in the number of families shown for each group.

[c] The figure in parentheses shows the significance level of the F value.

[d] Two parent families, as described here and in the variable named "One or two-parent family," are those in which there is a father and a mother. Single parents with live-in mates are counted as single persons.

6. An indication as to whether the child was considered physically handicapped in any way, including mental retardation, epilepsy, possible neurological impairment, etc., described as Handicaps in Chapter III.

7. Problems of family categorized as those mainly with the child, mainly parents' adult problems, or both types, described in Chapter III.

The zero-order correlations of each of these items with the Parent Change Score are shown in Table 1 in the Appendix.

## Parent and Child Change Scores

When the Parent's Change Score was regressed on the independent variables listed above, only two independent variables are significant (Table 37):

> Problems of the family mainly child, or adult, or both
> Mother's education

This finding is consistent no matter which of the groups in Table 37 is represented in the regression.

This finding is to be expected when the zero-order correlations of each of the independent variables with Parent Change Score are examined. The type of problems of the family (whether mainly in their interaction with the child, or adult problems of the parents, or both kinds) consistently shows the highest correlation with this measure of outcome, and is followed by the mother's educational level. The former variable could be regarded as an indication of the degree of seriousness of the problems within the family, and the second as an indication of the level of ability within the family. Obviously, neither of these interpretations is completely accurate, however. And it is apparent that the two variables taken together account at most for only about 19 percent of the variance of the Parent Change Score.

Information describing the Mother's Childhood was available only for two agencies, but since this detail seemed fairly important, it was included in additional regressions for two groups, with the results shown in Table 34.

## Table 38

Regression of Parent Change Score for Three Agencies on Independent Variables Including Mother's Childhood

| Group | Significant independent variables | Explained variance | Overall F value |
|---|---|---|---|
| HCT<br>FTP<br>OPT | 1. Mother's education<br>2. Mother's childhood<br>3. Problems mainly child, adult, or both | .220 | 7.51<br>(.000) |
| HCT | 1. Problems mainly child, adult, or both<br>2. Mother's childhood<br>3. Prior treatment | .330 | 9.7<br>(.000_ |

These findings suggest that in addition to the mother's education, her own childhood experience is a significant factor in her responsiveness to the intervention offered.

Two other variables that could only be examined for two-parent families were the Father's Employment Status (whether employed full-time, part-time, or unemployed) and the Parents' Relationship (rated on a five-point scale from close, supportive to problematic). When these were included along with the family and child characteristics, the Father's Employment Status was not significant in any of the equations. However, Parents' Relationship was the first variable entered, followed by Mother's Education in the prediction of the Parents' Change Score, and increased the proportion of explained variance from .134 to .222. This suggests that the relationship of the two parents with each other, whether close and supportive or distinctly problematic, has a significant effect on the responsiveness of the parents to the intervention.

The same procedure was used to determine the relationship of the family and child characteristics with the other measures of outcome.

There is greater variation in the independent variables related to Child Change Score for the various agencies, but very similar proportions of the variance in the outcome score can be explained by these except in the case of two and one-parent families (Table 39). Not surprisingly, the Degree of difficulty shown by the child is significant in most of the equations. The Reason for referral is significant for some groups, suggesting that, with the exception of FCS, placing the emphasis on the child's behavior in the home or child's limitations means a slightly greater likelihood of improvement in the child's behavior. For the FCS families, in which there is a high proportion of developmentally disabled children/youth, the reverse is true (as shown by the negative beta weight of this variable); when the child's behavior or limitations are the primary basis for referral, there is a lesser likelihood of improvement in the child's behavior.

The difference between two and one-parent families is of interest, as significantly more of the variance in the Child Change Score can be accounted for in the one-parent families by two variables. This suggests that single parents who have both adult and child problems, along with a very difficult child, are more clearly identified as less likely to respond to intervention reflected in their child's improved behavior then two-parent families.

The inclusion of Mother's Background and of Parents' Relationship has no effect in the prediction of the Child Outcome Score.

## Parent and Child Goal Outcomes

An examination of the relationship of the family and child characteristics with the extent to which the treatment goals for the parents and those for the child were attained shows that the same characteristics are important, with few exceptions.

A somewhat larger proportion of the variance in the Parent Goal Outcome (that is, average degree of attainment of the individual parent goals) can be accounted for by the same two variables as were significant for the Parent Change Score: Mother's Education and Problems mainly child, adult, or both (Table 40).

The inclusion of Mother's Childhood for HCT, FTP, OPT and for HCT alone and for two-parent families, of Parents' Relationship made no difference. Neither variable was significant.

Also, in the case of the Child Goal Outcome (that is, the average degree of attainment of the individual child goals), a somewhat larger proportion of the variance can be accounted for than in the prediction of the Child Change Score (Table 41). The Degree of difficulty presented by the child is of major importance for most of the groups. This means that the goals for the child (which generally refer to improvement in the child's behavior or adjustment) are somewhat less likely to be attained in the case of more difficult children -- a finding that is hardly surprising. Prior Treatment experienced by the family is significant for a number of the groups; this means that the specific goals for the child are somewhat more likely to be attained in families with previous experience of treatment. Possible such families are more highly motivated to work hard during this opportunity to obtain help. Prior Treatment is not significantly correlated with Degree of difficulty of the child for the total group or for the one-parent families.

For both FCS and two-parent families, the Degree of difficulty of the child has a considerably higher beta weight than the other equations. The child goals are much less likely to be attained in the case of the more difficult children in these two groups. Since a large majority of FCS families consist of two parents, there is considerable overlap between these two groups.

Table 39

Regression of Child Change Score on Independent Variables Describing Characteristics of Family and Child That Could Be Determined at Intake

| Group | Number of Families | Significant Independent Variables | Proportion of Explained Variance | F value |
|---|---|---|---|---|
| Total | 145 | 1. Problems of family mainly child, adult or both<br>2. Degree of difficulty of child | .115 | 9.345<br>(.000) |
| HCT<br>FTP<br>OPT | 110 | 1. Problems of family mainly child, adult or both<br>2. Degree of difficulty of child<br>3. Reason for referral<br>4. Mother's education | .193 | 6.69<br>(.000) |
| HCT | 69 | 1. Problems of family mainly child, adult or both | .185 | 13.78<br>(.000) |
| FCS | 35 | 1. Reason for referral | .087 | 4.06<br>(.053) |
| Two-parent families | 72 | 1. Degree of difficulty of child | .05 | 4.06<br>(.049) |
| One-parent families | 70 | 1. Problems of family mainly child, adult, or both<br>2. Degree of difficulty of child | .221 | 10.321<br>(.000) |

## Table 40

Regression of Parent Goal Outcome on Independent Variables Describing Characteristics of Family and Child That Could Be Determined at Intake

| Group | Number of Families | Significant Independent Variables | Proportion of Explained Variance | F value |
|---|---|---|---|---|
| Total | 136 | 1. Mother's education<br>2. Problems of family mainly child, adult or both | .208 | 16.93<br>(.000) |
| HCT<br>FTP<br>OPT | 98 | 1. Mother's education<br>2. Problems of family mainly child, adult or both | .208 | 12.21<br>(.000) |
| HCT | 68 | 1. Problems of family mainly child, adult or both<br>2. Mother's education | .251 | 10.22<br>(.000) |
| FCS | 38 | 1. Mother's education | .156 | 7.51<br>(.01) |
| Two-parent families | 67 | 1. Mother's education<br>2. Problems of family mainly child, adult or both | .226 | 9.03<br>(.000) |
| One-parent families | 66 | 1. Mother's education<br>2. Problems of family mainly child, adult or both | .201 | 8.776<br>(.000) |

Table 41

Regression of Child Goal Outcome on Independent Variables Describing Characteristics of Family and Child That Could Be Determined at Intake

| Group | Number of Families | Significant Independent Variables | Proportion of Explained Variance | F value |
|---|---|---|---|---|
| Total | 103 | 1. Degree of Difficulty of child<br>2. Problems of family mainly child, adult or both<br>3. Prior treatment<br>4. One or two-parent family | .212 | 7.32<br>(.000) |
| HCT<br>FTP<br>OPT | 66 | 1. Problems of family mainly child, adult or both<br>2. Degree of difficulty of child<br>3. Prior treatment<br>4. One or two-parent family | .234 | 5.52<br>(.000) |
| HCT | 54 | 1. Degree of difficulty of child<br>2. Problems of family mainly child, adult or both | .205 | 7.06<br>(.002) |
| FCS | 37 | 1. Degree of difficulty of child<br>2. Problems of family mainly child, adult or both | .339 | 9.73<br>(.001) |
| Two-parent families | 50 | 1. Degree of difficulty of child<br>2. Problems of family mainly child, adult or both | .463 | 19.56<br>(.000) |
| One-parent families | 50 | 1. Prior treatment<br>2. Problems of family mainly child, adult or both | .162 | 5.53<br>(.007) |

## RELATIONSHIP OF THE GOALS OF INTERVENTION WITH OUTCOME

Because of the large number of categories of goals, it was feasible only to include the totals of various groups in the regressions. The following were included:[1]

1. Parent goals in child management methods. This was a total of all of the specific goals coded in this category. Since there were marked differences in the total number listed for the different agencies, this total score was standardized to permit combination of the data from all the agencies and to indicate the relative emphasis this method was given in servicing a family rather than emphasizing differences between agencies when the regression was at 80 computed using actual scores and the results were very similar.

2. Parent goal of didactic training, coded simply as a stated or not stated goal.

3. Total of parent goals having to do with solving adult problems of the parent, also standardized to make them equivalent across agencies.

4. Total of parent goals to improve interaction with child, standardized across agencies.

5. Parent goal of improving relationship with spouse, coded simply as a stated or not stated goal. When coded for single parents, this goal indicated problems with live-in mates.

Specific separate goals for the child were stated only for two agencies, HCT and FCS. In earlier correlational analysis, it appears that they showed less relationship with outcome than the parent goals. Because of the missing data of two agencies they have not been used in the regressions reported.

When the outcome variables were regressed on the groups of parent goals, the amount of explained variance is even less than that accounted for by the characteristics of the family and child (Tables 42 and 43). In fact, it is so trivial as to be of no practical value in predicting outcome.

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[1] For more detail regarding the content of parent goals, the reader is referred to Chapter IV, where they are described in some detail.

Table 42

Regression of Parent Change Score on Parent Goals

| Group | Number of Families | Significant Independent Variables | Proportion of Explained Variance | F value |
|---|---|---|---|---|
| Total | | 1. Didactic training | .045 | 8.23<br>(.005) |
| HCT<br>FTP<br>OPT | 121 | 1. Didactic training<br>2. Training in child management methods | .09 | 6.88<br>(.001) |
| HCT | 70 | 1. Training in child management methods | .100 | 8.59<br>(.005) |
| FCS | 40 | None entered | | |
| Two-parent families | 78 | 1. Didactic training | .049 | 4.36<br>(.041) |
| One-parent families | 80 | 1. Resolve parent problems | .034 n.s. | 3.008<br>(.088) |

## Table 43

Regression of Child Change Score on Parent Goals

| Group | Number of Families | Significant Independent Variables | Proportion of Explained Variance | F value |
|---|---|---|---|---|
| Total |  | 1. Didactic training | .049 | 8.27<br>(.005) |
| HCT<br>FTP<br>OPT | 110 | 1. Didactic training | .04 | 5.95<br>(.016) |
| HCT | 69 | 1. Training in child management methods | .047 | 4.42<br>(.039) |
| FCS | 35 | None entered |  |  |
| Two-parent families | 72 | 1. Training in child management methods | .041 | 3.69<br>(.059) |
| One-parent | 70 | 1. Didactic training<br>2. Training in child management methods | .156 | 6.19<br>(.004) |

Although this lack of variance accounted for could be interpreted as indicating that the content of the goals is of little importance, we do not regard this as the most appropriate interpretation. The specific goals varied greatly for the families, and it seems likely that grouping them into the broader categories -- which was essential for statistical analysis -- could conceal much of their possible relationship to outcome. There is also a correlation between number of goals and length of treatment, indicating that more goals stated in the record may simply be a function of longer work with a family.

Work on teaching child management methods, or on providing didactic training to parent was an important and significant aspects of the intervention provided these families, as indicated by Table 1 in the Appendix.

Two of the outcome measures used, Parent Goal Outcome and Child Goal Outcome, are based on the same goals examined in these regressions. They consist of ratings of attainment of individual goals, not number of goals. Therefore, regressions are not reported for them.

## RELATIONSHIP OF PARENT PROBLEMS WITH OUTCOME

Also of interest in their relationship to outcome is the question of the problems revealed by the parents early in the intervention -- whether negative attitudes toward their child, problems in relationship with their spouse, or other kinds of problems in their own adult lives, or with their children. These are described in Chapter V and are listed in Table 33. They are a summary of more detailed problems coded as description of the holding environment, or of the parents' "core problem" that would need to be changed in order for the environment provided the child to improve, or of the parents' problems in their adult lives. In coding these details, however, a judgment always had to be made as to the most important problems as there would be space only to code two or three such details. This needs to be kept in mind when the findings regarding parent problems are examined.

Just as in the case of other groups of independent variables, however, there was too much information to use in statistical analysis. It was also evident that a number of the problem descriptions appeared unrelated to outcome. This could be interpreted as indicating that intervention was not directed toward these problems, or was ineffective, or that the ways in which the problems were grouped concealed some differences occurring in regard to more specific problems.

The following seven categories of problems were selected as each showed some relationship with outcome:

Problems of adult(s) alone, including the following:

Problems with adults other than spouse (generally a parent or former spouse)
Problems with spouse
Immaturity
Total adult problems

Problems in interaction with the child including:

- Negative interaction with child (lack of praise; attends to negative behavior)
- Lacks understanding of child's abilities and training potential
- None other than need to learn appropriate child management methods

The parent problems that have a significant effect on the Parent Change Score (Table 44) and Parent Goal Outcome (Table 45) are somewhat different from those that are related to Child Change Score (Table 46) and Child Goal Outcome (Table 47), and in general account for smaller proportions of variance in the parent outcome measures. Two variables, Total adult problems and Only needs to learn child management methods, appear only in the regressions for the parent outcome measures. They indicate that families with a greater number of adult problems are less likely to respond favorably to the intervention, while those who only need training in child management methods are somewhat more likely to do well and change their way of interacting with the child. This, of course, is not surprising, as the statement "only needs to learn child management methods" suggests that the family does not have extremely serious problems, either adult or child.

On the other hand, Problems with spouse and Problems with adults other than spouse are prominent in all of the regressions on Child Change Score, indicating that the greater these adult problems of the parents in relationship with other adults, the less likely is improvement in the child's behavior. Also significant in regression on the child outcome scores are Lacks understanding of child's abilities and training potential and Negative interaction with child. The latter is correlated directly with the two child outcome scores, suggesting that such a problem on the part of the parent (the lack of praise and attention to negative behavior) is more amenable to intervention than the other problems, and may serve to identify the parents more likely to respond to intervention. Also, since training in specific child management methods is very likely to emphasize the importance of praise and attention to the child for desirable behavior, this may be another factor contributing to the relative success with parents showing Negative interaction with child.

This is not the case for FCS or two-parent families, however, a group heavily weighted by FCS families. Those coded as showing Negative interaction are less likely to respond favorably to intervention: again, this may be in part attributable to attitudes toward severely handicapped children, and also possibly to the less emphasis FCS places on direct teaching of child management methods.

## RELATIONSHIP OF COMBINED INDEPENDENT VARIABLES WITH OUTCOME

After examining the effect of each of these groups of variables -- initial family and child characteristics, goals of intervention, and parent problems -- the next step was to combine them to determine whether outcome could be predicted from such a combination. Because there were too many to include in a regression, only the variables that showed a significant effect in one of the earlier equations were included. And since different variables were significant in the prediction of each of the four major outcome variables, this meant that a somewhat different list would be used for each equation. In the tables to follow, consequently, both the variables entering the equation and those not significant are shown.

Although there is some variation in the variables predicting Parent Change Score for the various groups, one variable appears in every equation except one: Problems of family mainly child, adult, or both (Table 48). This means that regardless of the way the groups of families from the four agencies are combined, those regarded as having primarily problems just with their child and not adult problems as well are more likely to respond well to the intervention. The one group in which this variable is not significant consists of two-parent families; for them the parents' relationship is the first variable entering, followed by negative interaction with child -- again with an inverse relationship with outcome, suggesting that two-parent families which such a problem are less likely to respond well to intervention. But this particular variable was not included in any of the other regressions of Parent Change Score.

The proportion of variance in this outcome measure that can be accounted for is still relatively small and of little practical value, suggesting that the combination of initial characteristics with methods used and parent problems is not of much help in identifying families that could be expected to respond well to intervention. The use of Didactic training is of value when the total group or the three agencies, HCT, FTP, and OPT, are considered while training in child management methods is of value for the HCT group. Several other indicators of the extent of the parents' problems appear; these include not only the type of problems but evidence of Problems with adults other than spouse, and the goal of Resolve parent problems for single parent families. And the statement Only need to learn child management methods implies the reverse, that the problems of the family are not serious. In general, then, these equations show what we might already have guessed, namely, that the families with more capable mothers (educationally) and with less severe problems are a little more likely to respond favorably.

Much the same conclusion may be reached in the regressions on Child Change Score, although the Degree of difficulty of the child also is important in most of these and is inversely related to better outcome (Table 49). But, again, this is one indication of the severity of the problems faced by the family. That substantially more of the variance (nearly half) in Child Change Score for one-parent families can be accounted for is of particular interest, with the rating of problems with child, adult or both contributing the most to the equation.

## Table 44

### Regression of Parent Change Score on Parent Problems

| Group | Number of Families | Significant Independent Variables | Explained Variance (adjusted) | F value |
|---|---|---|---|---|
| Total | 161 | Problems with adults other than spouse | .074 | 7.36 (001) |
| HCT<br>FTP<br>OPT | 121 | Total adult problems | .062 | 8.96 (.003) |
| HCT | 70 | Only need to learn child management methods<br>Problems with adults other than spouse | .186 | 8.89 (.000) |
| FCS | 40 | Problems with adults other than spouse<br>Negative interaction with child | .177 | 5.09 (.01) |
| Two-parent families | 78 | Total adult problems<br>Negative interaction with child | .120 | 6.25 (.003) |
| One-parent families | 80 | Problems with adults other than spouse | .061 | 6.09 (.016) |

Table 45

Regression of Parent Goal Outcome on Parent Problems

| Group | Number of Families | Significant Independent Variables | Explained Variance (adjusted) | F value |
|---|---|---|---|---|
| Total | 136 | 1. Problems with adults other than spouse<br>2. Total adult problems | .078 | 6.56 (.002) |
| HCT<br>FTP<br>OPT | 98 | 1. Immaturity | .061 | 7.20 (.009) |
| HCT | 68 | 1. Total adult problems | .055 | 4.91 (.03) |
| FCS | 38 | 1. Problems with adults other than spouse | .175 | 8.44 (.006) |
| Two-parent families | 67 | 1. Total adult problems | .111 | 9.14 (.004) |
| One-parent families | 66 | 1. Immaturity<br>2. Negative interaction with child | .127 | 5.74 (.005) |

Table 46

Regression of Child Change Score on Parent Problems

| Group | Number of Families | Significant Independent Variables | Explained Variance (adjusted) | F value |
|---|---|---|---|---|
| Total | 145 | 1. Problems with adults other than spouse<br>2. Problems with spouse<br>3. Lacks understanding of child's abilities and training potential<br>4. Immaturity | .163 | 7.90 (.000) |
| HCT<br>FTP<br>OPT | 121 | 1. Problems with adults other than spouse<br>2. Lacks understanding of child's abilities and training potential<br>3. Problems with spouse | .097 | 4.89 (.003) |
| HCT | 69 | 1. Only needs to learn child management methods<br>2. Lacks understanding of child's abilities and training potential<br>3. Problems with adults other than spouse<br>4. Problems with spouse | .172 | 4.5 (.003) |
| FCS | 37 | 1. Problems with spouse<br>2. Problems with adults other than spouse | .289 | 7.49 (.002) |
| Two-parent families | 72 | 1. Lacks understanding of child's abilities and training potential<br>2. Problems with spouse<br>3. Problems with adults other than spouse | .132 | 4.55 (.006) |
| One-parent families | 70 | 1. Problems with adults other than spouse<br>2. Negative interaction with child | .157 | 7.40 (.004) |

## Table 47

### Regression of Child Goal Outcome on Parent Problems

| Group | Number of Families | Significant Independent Variables | Explained Variance (adjusted) | F value |
|---|---|---|---|---|
| Total | 103 | 1. Negative interaction with child<br>2. Immaturity | .104 | 6.87 (.002) |
| HCT<br>FTP<br>OPT | 66 | 1. Immaturity<br>2. Negative interaction with child | .128 | 5.77 (.005) |
| HCT | 54 | 1. Total adult problems<br>2. Negative interaction with child | .119 | 4.61 (.015) |
| FCS | 37 | 1. Lacks understanding of child's abilities and training potential<br>2. Problems with spouse | .182 | 4.89 (.014) |
| Two-parent families | 50 | 1. Lacks understanding of child's abilities and training potential<br>2. Total adult problems | .111 | 4.06 (.02) |
| One-parent families | 50 | 1. Negative interaction with child<br>2. Immaturity | .231 | 8.37 (.001) |

## Table 48

### Regression of Parent Change Score on Combined Independent Variables

| Group | Number of Families | Significant Independent Variables | Non-significant Independent Variables | Explained variance (adjusted) | F value |
|---|---|---|---|---|---|
| Total | 161 | Problems mainly child, adult or both<br>Problems with adults other than spouse<br>Mother's education<br>Didactic training | Only needs to learn child management methods | .178 | 7.06 (.000) |
| HCT<br>FTP<br>OPT | 121 | Mother's education<br>Didactic training<br>Problems mainly child, adult or both<br>Only needs to learn child management methods | Training in child management methods<br>Problems with adults other than spouse<br>Total adult problems | .227 | 9.14 (.000) |
| HCT | 70 | Problems mainly child, adult or both<br>Training in child management methods<br>Only needs to learn child management methods | Mother's education<br>Problems with adults other than spouse | .283 | 9.9 (.000) |
| FCS | 40 | Problems with adults other than spouse<br>Problems mainly child, adult or both<br>Negative interaction with child | None | .243 | 5.07 (.005) |
| Two-parent families | 78 | Parents' relationship<br>Negative interaction with child<br>Mother's education | Didactic training<br>Total adult problems | .258 | 9.1 (.000) |
| One-parent families | 80 | Problems mainly child, adult or both<br>Resolve parent problems<br>Problems with adults other than spouse | None | .231 | 8.52 (.000) |

Table 49

Regression of Child Change Score on Combined Independent Variables

| Group | Number of Families | Significant Independent Variables | Non-significant Independent Variables | Explained variance (adjusted) | F value |
|---|---|---|---|---|---|
| Total | 145 | Problems mainly child, adult or both<br>Problems with adults other than spouse<br>Problems with spouse<br>Degree of difficulty of child<br>Didactic training<br>Lacks understanding of child's abilities and training potential | Immaturity | .243 | 8.53 (.000) |
| HCT<br>FTP<br>OPT | 110 | Problems mainly child, adult or both<br>Degree of difficulty of child<br>Didactic training<br>Reasons for referral<br>Problems with adults other than spouse<br>Mother's education | Problems with spouse | .257 | 6.95 (.000) |
| HCT | 69 | Problems mainly child, adult or both<br>Lacks understanding of child's abilities and training potential<br>Training in child management methods<br>Degree of difficulty of child | Problems with adults other than spouse<br>Problems with spouse<br>Only needs to learn child management methods | .287 | 7.8 (.000) |
| FCS | 35 | Problems with spouse<br>Problems with adults other than spouse | Lacks understanding of childs abilities and training potential | .289 | 7.49 (.002) |
| Two-parent families | 72 | Lacks understanding of child's abilities and training potential<br>Training in child management methods<br>Degree of difficulty of child | Problems with adults other than spouse<br>Problems with spouse | .172 | 4.58 (.003) |
| One-parent families | 70 | Problems mainly child, adult or both<br>Resolve adult problems<br>Didactic training<br>Negative interaction with child<br>Problems with adults other than spouse<br>Degree of difficulty of child | Problems with mate | .479 | 11.26 (.000) |

The variance in the attainment of parent goals and child goals can be accounted for to a somewhat greater extent than that in the change scores (Tables 50 and 51), although the particular independent items contribution in each remain much the same. The mother's educational level and the type of problems (whether mainly child, adult, or both) remain important, but Resolve parent problems appears in several equations, and Total adult problems appears in another. In one sense, these are both indications of the number of problems the parent appears to have as an adult (not relative to the child), but the former is a summary of the number of goals focused on this area while the latter is simply the total of problems in this area. Somewhat more of the variance in the goal outcomes can be accounted for, but the reduction in the number of families in each group as a result of missing information on the goal outcome variables is serious and reduces our confidence in the regressions.

## INCLUSION OF A PROCESS VARIABLE, THE PARENTS' DEFENSIVENESS DURING INTERVENTION

In addition to the goals, which in one sense describe the process of intervention, the rating of Defensiveness of the parent (generally the mother but including the single fathers) was included in the regressions as an indication of how the parent responded to the agency efforts to bring about this change. As is apparent in Table 48, this rating appears first in the regressions on Parent Change Score, regardless of the group examined. In one sense this, too, could be expected, as parents who appear defensive (in the sense of not cooperating fully in the treatment -- not completing assignments, being unwilling to try new approaches, etc.) would not be expected to receive high ratings on a change score. Forty-three percent of the variance in Parent Change Score for the total group of 161 families can be accounted for by this rating along with the type of problem the family presents (child, adult, or both), while 47 percent of the variance in the same score for three agencies combined (HCT, FTP, and OPT) can be accounted for by the same two variables along with the mother's educational level and the extent to which training in child management methods received emphasis (Table 52).

When the parent's defensiveness is included with the other independent variables in regressions or Child Change Score, the main differences from the earlier regressions reported in Table 49 are that Degree of difficulty of the child and Didactic training drop out of all of the equations in which they appeared (as did several other variables that appear in only one), while the accounted-for variance increases by about ten percentage points (Table 53). For the total group of families, 43 percent of the variance may be accounted for by five independent variables, and 55 percent of the variance in the three groups combined (HCT, FTP, and OPT).

In regressions of Parent Goal Outcome (Table 54), the Mother's defensiveness enters first, but the other significant variables are very similar to those in the earlier equations (Table 50), although the accounted-for proportion of variance increases by about ten percentage points. The mother's educational level, the type of problems the family has, and the total number of goals related to resolving parent problems are important in both.

Table 50

Regression of Parent Goal Outcome on Combined Independent Variables

| Group | Number of Families | Significant Independent Variables | Non-significant Independent Variables | Explained variance (adjusted) | F value |
|---|---|---|---|---|---|
| Total | 136 | Mother's education<br>Problems mainly child, adult or both<br>Resolve parent problems<br>Problems with adults other than spouse<br>Total adult problems | Didactic training | .301 | 12.4 (.000) |
| HCT<br>FTP<br>OPT | 98 | Mother's education<br>Resolve parent problems<br>Problems mainly child, adult or both<br>Didactic training<br>Immaturity | None | .421 | 14.9 (.000) |
| HCT | 68 | Problems mainly child, adult or both<br>Mother's education | Training in child management methods<br>Total adult problems | .256 | 12.5 (.000) |
| FCS | 38 | Problems with adults other than spouse<br>Mother's education | Problems mainly child, adult or both<br>Improve relationship with spouse | .326 | 9.48 (.001) |
| Two-parent families | 67 | Mother's education<br>Problems mainly child, adult or both<br>Total adult problems | None | .266 | 8.72 (.001) |
| One-parent families | 66 | Mother's education<br>Resolve parent problems<br>Immaturity<br>Negative interaction with child | Problems mainly child, adult or both | .345 | 9.43 (.000) |

## Table 51

### Regression of Child Goal Outcome on Combined Independent Variables

| Group | Number of Families | Significant Independent Variables | Non-significant Independent Variables | Explained variance (adjusted) | F value |
|---|---|---|---|---|---|
| Total | 103 | Degree of difficulty of child<br>Didactic training<br>Resolve parent problems<br>Problems mainly child, adult or both<br>Negative interaction with child<br>Immaturity | Prior treatment<br>One or two parents present | .309 | 8.02 (.000) |
| HCT<br>OPT<br>FTP | 66 | Resolve parent problems<br>Problems mainly child, adult or both<br>Negative interaction with child<br>Immaturity<br>Degree of difficulty of child<br>Didactic training | Prior treatment<br>One or two parents present | .487 | 10.34 (.000) |
| HCT | 54 | Degree of difficulty of child<br>Resolve parent problems<br>Problems mainly child, adult or both<br>Negative interaction with child | Didactic training<br>Total adult problems | .471 | 12.79 (.000) |
| FCS | 37 | Degree of difficulty of child<br>One or two parents present | Help child with specific needs<br>Lacks understanding of child's abilities & training potential<br>Problems with spouse | .339 | 9.73 (.000) |
| Two parent families | 50 | Degree of difficulty of child<br>Problems mainly child, adult or both | Help child with specific needs<br>Lacks understanding of child's abilities & training potential<br>Total adult problems | .464 | 20.5 (.000) |
| One parent families | 50 | Negative interaction with child<br>Resolve parent problems<br>Problems mainly child, adult or both<br>Prior treatment<br>Immaturity | Didactic training | .479 | 9.44 (.000) |

Table 52

Regression of Parent Change Score on Combined Independent Variables Including Mother's Defensiveness

| Group | Number of Families | Significant Independent Variables | Proportion of Explained Variance | F value |
|---|---|---|---|---|
| Total | 161 | Mother's defensiveness<br>Problems mainly child, adult or both | .437 | 58.36 (.000) |
| HCT<br>FTP<br>OPT | 121 | Mother's defensiveness<br>Mother's education<br>Training in child management methods<br>Problems mainly child, adult or both | .477 | 34.69 (.000) |
| HCT | 70 | Mother's defensiveness<br>Problems mainly child, adult or both<br>Training in child management methods | .508 | 24.35 (.000) |
| FCS | 40 | Mother's defensiveness<br>Problems mainly child, adult or both | .328 | 9.52 (.001) |
| Two-parent families | 78 | Mother's defensiveness<br>Parents' relationship<br>Negative interaction with child | .550 | 29.54 (.000) |
| One-parent families | 80 | Mother's defensiveness<br>Problems mainly child, adult or both | .443 | 30.40 (.000) |

Table 53

Regression of Child Change Score on Combined Independent Variables Including Mother's Defensiveness

| Group | Number of Families | Significant Independent Variables | Variables not Entering Equation | Explained variance (adjusted) | F value |
|---|---|---|---|---|---|
| Total | 145 | Mother's defensiveness<br>Problems with spouse<br>Problems mainly child, adult or both<br>Problems with adults other than spouse<br>Lacks understanding of child's abilities and training potential | Degree of difficulty of child | .337 | 15.33 (.000) |
| HCT<br>FTP<br>OPT | 110 | Mother's defensiveness<br>Problems mainly child, adult or both<br>Reasons for referral<br>Degree of difficulty of child<br>Problems with adults other than spouse | Mother's education<br>Didactic training<br>Problems with spouse | .386 | 13.9 (.000) |
| HCT | 69 | Mother's defensiveness<br>Problems mainly child, adult or both<br>Lacks understanding of child's abilities and training potential<br>Resolve parent problems | Degree of difficulty of child<br>Only needs to learn child management methods<br>Training in child management<br>Problems with adults other than spouse<br>Problems with spouse | .373 | 14.5 (.000) |
| FCS | 35 | Problems with spouse<br>Problems with adults other than spouse | Reasons for referral<br>Degree of difficulty of child<br>Lacks understanding of child's training potential<br>Mother's defensiveness | .289 | 7.49 (.002) |

Table 53 (continued)

| | | | | | | |
|---|---|---|---|---|---|---|
| Two-parent families | 72 | Mother's defensiveness<br>Lacks understanding of child's abilities and training potential<br>Relationship of parents | Degree of difficulty of child<br>Training in child management methods<br>Problems with adults other than spouse<br>Problems with spouse | .175 | 5.87 | (.001) |
| One-parent families | 70 | Mother's defensiveness<br>Problems with spouse<br>Problems mainly child, adult or both<br>Resolve parent problems<br>Negative interaction with child<br>Problems with adults other than spouse | Degree of difficulty of child<br>Didactic training | .599 | 17.4 | (.000) |

Table 54

Regression of Parent Goal Outcome on Combined Independent Variables Including Mother's Defensiveness

| Group | Number of Families | Significant Independent Variables | Variables not Entering Equation | Explained variance (adjusted) | F value |
|---|---|---|---|---|---|
| Total | 136 | Mother's defensiveness<br>Mother's education<br>Problems mainly child, adult or both<br>Problems with adults other than spouse | Didactic training<br>Total adult problems | .432 | 21.12 (.000) |
| HCT<br>FTP<br>OPT | | Mother's defensiveness<br>Mother's education<br>Resolve parent problems<br>Problems mainly child, adult or both<br>Immaturity<br>Didactic training | None | .559 | 21.27 (.000) |
| HCT | 68 | Mother's defensiveness<br>Mother's education<br>Problems mainly child, adult or both | Training in child management methods | .421 | 17.22 (.000) |
| Two-parent families | 67 | Mother's defensiveness<br>Problems mainly child, adult or both<br>Mother's education | Total adult problems | .378 | 13.99 (.000) |
| One-parent families | 66 | Mother's defensiveness<br>Mother's education<br>Resolve parent problems<br>Immaturity<br>Negative interaction with child | Problems mainly child, adult or both | .523 | 14.8 (.000) |

Because of the smaller number of cases available for the use of Child Goal Outcome, these regressions are not reported in a table here. The Degree of difficulty of the child remains significant, but the rating of the mother's defensiveness enters first. Negative attitude toward the child is significant in the regressions for both the total group and for the combined three agencies (HCT, FRP, and OPT), and is directly related to attainment of the child goals, just as in the earlier regressions reported for child outcome. In one sense, it could be regarded as an indication that the interactional problems of the parent with child are not as serious as in other families, and hence is more likely to be changed by the intervention.

## INCLUSION OF THE MOTHER'S DEVELOPMENTAL LEVEL

The importance of the mother's developmental level as an important determinant of the responsiveness to the intervention is illustrated in Table 32. Because it is a concept with which workers are unlikely to be familiar, we have not included it in the regressions described above. Also, it is available only for three groups -- HCT, FTP, and OPT -- so number of cases is smaller.

Since it is fairly highly related to the rating of the mother's defensiveness, it always entered first and frequently was in combination with other independent variables similar to those that were combined with mother's defensiveness. The variance accounted for, however, was uniformly somewhat lower than that shown in Tables 52 and 53, when mother's defensiveness was used.

When the mother's developmental level was entered along with mother's defensiveness and other significant independent variables, the variance accounted for in the Parent Change Score for the three agencies increases from .477 to .526. The change in regard to the Child Change Score is negligible, an increase in the variance accounted for from .386 to .396.

## CAN WITHDRAWAL FROM TRETMENT BE PREDICTED

In Chapter IV a number of the characteristics of the families who withdrew from treatment were described. There seemed to be merit in testing the possibility of predicting withdrawal from a combination of these characteristics, including family characteristics and problems known to be related to service completion. As is evident in Table 55, the mother's defensiveness was the strongest direct predictor of withdrawal, followed by the total number of goals relating to parents' problems, a need only to learn child management methods (correlated inversely), and evidence that the parent lacked understanding of the child.

The similarity between these significant predictive items with those that are significant in predicting the final outcome measures suggests that not completing treatment and outcome are highly related, and they are. Completion of treatment shows the highest correlation with the two ratings of parent outcome, Parent Change Score and Parent Goal Outcome (.634 and

.601 respectively). Neither the Degree of difficulty of the child nor evidence that the child is Handicapped have any relationship with treatment completion, however. And the types of problems the family has is barely significant at the .02 level.

A ONEWAY Anova indicates that the three outcome groups (withdrew, did not complete for other reasons, and completed treatment) differ significantly from one another on all four of the primary outcome measures with one exception: on Child Goal Outcome the only significant difference is between those who completed treatment and those who withdrew.

Table 55

Regression of Treatment Completion on Combined Independent Variables Including Mother's Defensiveness

| Group | Number of Families | Significant independent variables | Variables not entering equation | Explained variance (adjusted) | F value |
|---|---|---|---|---|---|
| Total | 158 | Mother's defensiveness<br>Resolve parent problems<br>Only need to learn child management methods<br>Lacks understanding of child | Mother's age<br>Mother's education<br>Parents' philosophy of parenting<br>Lacks skills in parenting<br>Total number of parent goals | .354 | 21.17<br>(.000) |

## IS OUTCOME RELATED TO LENGTH OF TREATMENT?

In Table 56 is shown the relationship of the number of months and the number of hours of service a family received with the Parent Change Score. The correlations indicate that the longer a family was in treatment, measured both in number of months and number of hours of services received, the more favorable was the Parent Change Score. This significant correlation holds true for all agencies together, for the three agencies who do not differ significantly in terms of length of services provided, and then for each agency individually except FTP and OPT for months of service.

These significant correlations hold for other outcome measures, for example, increased praise, improved interaction in family, average attainment of specific child and parent goals, and average improvement in use of child management methods, both for the group of three agencies with similar lengths of treatment, and the agencies individually with the exception of FTP and OPT. In general, months of service are correlated more highly with outcome than hours of treatment, although the reverse is true for the OPT data.

## Table 56

Correlations of Parent Change Score with Months and Hours of Treatment

| | Agency | | | | | |
|---|---|---|---|---|---|---|
| | ALL | HCT,FCS,FTP | HCT | FCS | FTP | OPT |
| **Months** | .244 | .269 | .278 | .307 | .184 | .1938 |
| p.= | .001 | .001 | .01 | .03 | NS | NS |
| N = | N=159 | N-127 | N=68 | N=40 | | N=32 |
| **Hours** | .183 | .178 | .194 | .215 | Data | -.333 |
| p.= | .01 | .03 | .06 | .09 | missing | .04 |
| N = | N=137 | N=108 | N=68 | N=40 | | N=29 |

When both length of time and number of hours were entered in the regression, the overall prediction value of the equation was significant for all combinations of agencies at p. = .02. However, the number of months of service accounted for nearly all of this relationship and appears to be more important than number of hours of service. The two variables are highly correlated with an r of .847, as is to be expected. When the interaction term is introduced into the question, the overall regression remains significant; however, only number of months of service again contributes to the regression model.

It thus appears that number of months of service is of more value and indeed probably measures a very similar relationship than actual number of hours of service. However, despite the fact that number of months is significantly related to outcome for the three agencies and for each agency alone, it actually accounts for vey little of the variance in outcome. For the three agencies, only eight percent of the variance in the Parent Change Score is attributable to the length of time the family is in treatment. And when length of treatment is entered into an equation including background variables, problems and methods, it does not contribute significantly to the multiple correlation.

## SUMMARY

In this chapter the possibility of "explaining" or accounting for the outcome scores by combinations of independent variables was examined. First, using the characteristics of the family and child that could be known at the time of intake, including a categorization of the reasons for referral (arranged in order of implied criticism of the parent), we found that only a relatively small proportion of the variance in the Parent Change Score could be accounted for, ranging from 12 percent for the total group of families to 19 percent for the HCT families. The only variables entering were the mother's educational level and the type of problems of the family whether primarily problems with the child, adult problems of the parent, or both types. Although slightly more of the variance in Parent Goal Outcome could be accounted for (ranging from 20 percent for the total group to 25 percent for HCT), only the same two variables were significant.

When outcomes pertaining to the child were examined (The Child Change Score and the Child Goal Outcome), a similar picture emerges, but with Degree of difficulty of the child prominent in the equations.

When the outcome measures are regressed on the goals of treatment, Didactic training and Training in child management methods are significant in most of the equations, but account for only a trivial proportion of the variance in either the Parent Change Score or the Child Change Score. Resolve parent problems appears only in the regression of Parent Change Score for one-parent families.

The categorization of parent problems, on the other hand, contributes considerably more to understanding outcomes for some of the sub-groups of families, but accounts for relatively little variance when the total group is examined. This may be because of the variation in approach to parent problems by the different agencies. This is the case for both measures of parent outcome, Parent Change Score and Parent Goal Outcome. On the other hand, slightly more of the variance can be accounted for in the child outcome measures, and the variables that are significant indicate that both the parents' adult problems (particularly with adults other than spouse as well as with spouse) and the problems in attitude or interaction with child are related to the extent to which the child changes or the goals for the child are attained. Intervention is slightly less likely to be effective with parents who have adult problems in relationship with others, or lack understanding of the child. However, the inverse relationship of Negative interaction with child (referring specifically to lack of praise and attention to negative behavior) with child outcome suggests that this particular attitude is amenable to the type of intervention used. An exception is found in the FCS and two-parent families, in which the relationship is direct; that is, families with this problem are less likely to respond to the intervention. We suggest that this difference may be due in part to the different kind of client families served by FCS, particularly in terms of the older ages of the children, and the somewhat different emphasis in treatment in this agency, which is more didactic and counseling oriented.

A combination of significant variables from these three groups of variables produces some increase in the proportion of variance that can be accounted for in the outcome measures, considerably more in regard to the two measures based on the attainment of goals than in those based on change in either parent interaction with the child or in the child. Only 18 to 24 percent of the variance in Parent Change Score and Child Change Score can be accounted for in the total group of families, whereas 30 percent of the variance in Parent Goal Outcome and Child Goal Outcome can be accounted for by the combined independent variables. Throughout all of this analysis, it is generally the case that more capable parents (as indicated by educational achievement) with fewer problems of their own and with less difficult children, are likely to do better with the intervention offered. But much of the variance remains unaccounted for. What can be said of the exceptions, those who do not fit these characterizations? This is a question to be addressed in the last chapter.

The inclusion of a variable describing one aspect of the parent's responsiveness to the intervention, Defensiveness, changes the picture. As could be anticipated simply from the definition of this variable (defending or protecting oneself from the proposed changes or from the attempt to teach or help the parent to change or possibly even from the idea that any change is needed), it plays a very important part in the regressions when entered. It shows the highest standardized beta weight in almost all of the equations, and increases the variance accounted for in the total group of families by 25 percent for the Parent Change Score and by 10 percent for the Child Change Score percent. Some of the implications of this characteristic of the parents (primarily mothers) will be examined in the last chapter.

The length of time the agency works with the family, whether measured in number of months or hours, is significantly related to outcome, but only to a minor extent, accounting for 8 percent of the variance in the Parent Change Score. When combined with other independent variables, it becomes insignificant.

When the families who withdrew from treatment because they did not wish to continue are compared to those who withdrew for other reasons (such as moving away), and with those who remained working with the agency as long as the staff regarded it desirable, each group differed significantly from the others on three of four outcome measures. Similar independent variables were of use in accounting for withdrawal as for outcome, suggesting that this could be used as a different type of outcome measure.

# CHAPTER VII
# COST OF SERVICES

## COMPARISON WITH COSTS OF ALTERNATIVE SERVICES

A typical mode of examining the costs of services is to compare them with other alternatives that might have been utilized if the intervention being examined had not been available. In general, these would most probably have been removal of the "targeted child" to one of the following placements:

a. To a foster home or group home
b. To a private institution for the emotionally disturbed
c. To a State Institute for the emotionally disturbed

Obviously, not all the children would have required removal from their homes, and we are hardly in a position to make such a prediction. However, it is not unreasonable to estimate that all of those rated "very" or "extremely difficult" (46 percent of the total) would be at risk of removal.

The costs of each of these alternative placements are described here, but they take into account only the cost of care for the "targeted child," although in some instances the institution provides services to the family while a child resides in the institution.

The average cost of foster care in Wisconsin for 5 to 18 year old children/youth is $225 per month, or $2,696 per year. With an average stay in foster care of 3¼ years, this means total direct costs of $8,762 per child. This figure does not include medical assistance costs, social worker time, nor the supplemental rate of pay foster parents can receive for a child with special problems which can increase the total direct cost of foster care to $1,500 per month.

Group home rates for child care in the state are set by contract with the individual homes, including a child care cost plus a social service fee. Information regarding the average cost and length of stay are not available for group homes.

The average private Child Caring institution in Wisconsin currently charges $2,397 per month. With an average length of stay of 15 months, this means an average cost of $35,955 to maintain a child in an institution. Even with the current projections of a reduction in average length of stay to one year in the near future, the average cost would be $28,764 to provide services to one child of a family.

There are two public institutions which provide residential treatment to children in Wisconsin. Mendota Mental Health Institute has an average cost of approximately $3,224 per month increased to $225 per day on October 1, 1982, while Winnebago Mental Health Institute has an average cost of $2,180 per month. The average length of stay at Mendota is about one year, while that at Winnebago is approximately seven months. This would come to an average in 1982 of $38,688 to treat a child at Mendota and $15,260 at Winnebago[1].

It appears that the cost of providing alternative services to many of these families would be substantially greater if the child/youth had to be removed from the home and placed either in foster care or in a residential treatment institution. If removal of the "targeted child" were not required, there is very little information available regarding any services the family could receive that would seem likely to provide the fairly intensive kind of help these four agencies offered to their client families. The advantages of working with the entire family, as each of these groups has done, are that the parents responding to the intervention are likely to improve their parenting and interaction with all of their children, not just the "targeted child."

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[1] The charge at Mendota Mental Health Institute for 1983 was increased to $225 per day, making a monthly rate of $6,750 and a yearly rate of $81,000.

# CHAPTER VIII
# SUMMARY AND IMPLICATIONS

The records of four agencies providing intensive in-home services to families referred because of problems in parent-child interaction have been analyzed in order to increase understanding of the entire process of intervention, the goal of which in general is to improve the environment provided the child and prevent the removal of many of the children to substitute care. The characteristics of the families and the children have been examined, along with the methods of working with the families, the specific goals of the intervention, and the effectiveness of the work.

The client families served by three agencies differed significantly from the HCT group, which was the forerunner of the others and provided the largest number of cases for the study. The FCS families consisted of older parents and older children, with a majority of the children showing a developmental disability, the FTP families showed a large proportion referred for abuse or neglect of their children, while the OPT families had the youngest and least difficult group of children. Nearly one-half of the total group of 167 were single parent families. We have regarded these differences as an asset to the study, making any findings more generally applicable to the service field than if based on one agency's work.

Each agency used systematic observation of interaction of the entire family in the home as a means of gaining understanding of what was actually going on in the family, including the antecedents and consequences of each child's behavior. And each agency provided didactic training regarding child development and principles of behavior change for the families served, worked directly with parents and child together to help them learn more appropriate methods of interaction, and provided counseling and help to the majority of parents having problems in their own adult lives quite apart from their problems with their children.

Assessing the outcome of the intervention efforts was a crucial question: how could one determine which families were more responsive or made greater change in their interaction with their child when the individual problems were so different? We used not only indications that the child's actual behavior at home and at school had improved -- possibly the best criterion of effectiveness although sometimes not readily judged from the records -- but also many indications of whether the parents had improved their ways of interaction with their child. Were they more appropriately meeting the child's needs for nurturance, for structure, for positive attention? In short, had they made improvements in the environment provided the child? In these many detailed ratings we were greatly influenced by Robert Kegan's constructive-developmental theory (1982) in which he describes the process of growth in which the child and also the adult "makes meaning" of the world (environment) around.

Four primary outcome measures were developed.

1. The Parent Change Score was a composite based on five kinds of evidence all highly correlated with each other, namely, the extent to which the parent at the end of the intervention was providing sufficient nurturance, structure, and praise to the child, and, when appropriate, was providing opportunities for the child to show competence and self-sufficiency, along with a more general rating of the extent to which the parent's interaction with the child had improved.

2. The Child Change Score, based on two ratings of whether and the extent to which the child's behavior at home had improved and (when this information was available) whether his/her behavior at school had improved.

3. The Parent Goal Outcome, an average based on individual ratings of the extent to which each of the goals of treatment for the parent had been attained.

4. The Child Goal Outcome, an average based on individual ratings of the extent to which each of the goals of treatment for the child had been attained. This information was available only for two agencies, as in FTP and OPT work, the focus was primarily on the parents.

The relationship of these measures is high, represented by a correlation of .77 between the two Change Scores and of .76 between the Parent Change Score and Parent Goal Outcome. Since the coding of these details was done at a very different point in the coding process, this relatively high relationship increases our confidence in the use of these measures. Further, the ratings of the extent of change the parent had made in the environment provided the child and in resolving the "core problems" that needed attention before the environment could be expected to improve, showed equally high correlations with the four outcome measures.

The findings indicate that certain kinds of families were likely to respond more favorably to the intervention efforts made. On the whole, they were somewhat more capable, as indicated by the mother's educational attainment, and had somewhat less serious problems in the following areas; the type of problem evidenced, mainly with their child rather than adult problems of the parents or both types, the total number of adult problems, the level of difficulty presented by the child's behavior, and also, when available, evidence that the mother had an unhappy childhood. Two-parent families were likely to be somewhat more responsive than one-parent families, although the evidence of relationship problems of a parent with spouse was a negative indicator, while the evidence of a close, supportive relationship of husband and wife was a positive indicator. The fact that a family had experience with prior treatment (which it must be assumed was at least to some extent ineffective) also contributed positively to outcome. It seems likely that this might have been a motivating factor in some instances, with the family determined to try to make changes, or that it had a positive effect through convincing the family of the need to attend to their problems. The HCT group for a number of years has recognized this by requiring that some other means of treatment have been tried with the family before accepting them.

The particular goals of intervention, when examined alone, contributed relatively little to the understanding of outcome. But when combined with characteristics and problems of the families, the goals of resolving parent adult problems were important, particularly in regard to attaining the goals for the child. This suggests that work directed toward helping the parents solve their own problems (for the majority who had such problems) was important and often essential before they could be expected to improve their ways of interacting with their child.

Such a finding raises a question regarding the way in which referrals are presented to families. If the family is told that the agency "can help you with the problems you are having with your child," thereby placing the emphasis on the parenting role, it may be difficult for the staff to offer help to the parent regarding their own problems, even when it may be apparent that these need attention first. If the referral is voiced more in terms of "the problems you have mentioned need attention, and -- agency is able to provide the kinds of help families need," there might not be as great a barrier to the parents' accepting concern and counseling on the part of the staff for their own problems. On the other hand, it is generally less threatening to the parents to start working on their methods of child management, a factor that must also be taken into account.

Of far greater importance than any other single item in accounting for the differences in outcome was the rating of the parent's "defensiveness" shown during the work with the family. This means the extent to which the parent (primarily the mother) appeared to be defending or protecting herself from any change, such as considering, accepting, or trying out ideas and suggestions made by the staff. This attitude was often evident early in treatment and could be considered an indication that the intervention was not likely to be effective.

The length of time the staff members worked with families was relatively unimportant, but whether the family completed treatment, that is, remained working with the staff as long as the staff believed important, was significant. Families who withdrew because they did not wish to continue made an extremely limited response to the intervention, as would be expected. Also, significantly related to withdrawal from treatment was the rating of the mother's "defensiveness," suggesting that this was one important way in which it could be shown by the parent.

Another important aspect of the process of treatment was the extent of effort to involve the father and his response to this effort. Although all the agencies had as their goal the involvement of the entire family, they differed somewhat in the relative emphasis placed on involving the father. This detail was not available for all agencies and hence could not be used in the major analysis of the data, but when used, it was very important and significantly related to the effectiveness of the intervention.

Although it has been possible to account for much of the variation in the effectiveness of work with the families included in this study (or to put this in statistical terms, to account for about half the variance in the outcome measures), through a combination of the characteristics of the families, the particular problems of the parents, the goals of intervention, and the parent's defensiveness during treatment, there is still much to be understood regarding the process of helping a family change some of its patterns of behavior and improve its functioning. We have found Robert Kegan's (1982) constructive-developmental theory particularly helpful in enabling us to understand why work with some families was far more effective than in other instances, as there is no question that the staffs involved were highly motivated, concerned for the families referred and very conscientious in their work.

## Considering the Holding Environment Provided the Parent

One of Kegan's contributions is that a "holding environment" exists for everyone, adults as well as children. This is the setting in which the individual lives and functions. Kegan terms it as "the very context in which, and out of which, the person grows." (1982, p. 116). The three functions of this environment (described in more detail in Chapter III) are the following:

1. Confirming the individual or "holding" securely

2. Providing contradiction or "letting go" (permitting the individual to grow and to separate)

3. Providing continuity or "sticking around" (staying put while the individual reintegrates)

The first requirement for work with a client, someone who has been referred because of a "problem," is clearly to confirm that individual. Some ways in which this may be shown are showing respect for them, attending to the pain they and their children are experiencing, and listening carefully to what they have to say.

Even the way in which referral is handled can be helpfully viewed in this way. If stated in terms that imply, or say clearly, as sometimes occurs, that the parent is at fault or inadequate, this is certain to be threatening to the parent as it is disconfirming. This is likely to be the case particularly when the child's problem behavior is first noted by persons outside the home, as in the school, while the parent(s) may not be aware of it and deny it, or believe it will "go away." Such a referral may arouse immediate resistance and defensiveness (which, once aroused, may be very difficult to assuage).

Confirming a parent would be the first requirement of the staff expecting to try to work with the family.

This is one reason it may be advantageous to provide the kinds of services described here outside the public agency structure, as too frequently the client's past experience with the agency may have been frustrating and discouraging, or disconfirming in its implied or explicit criticism of the parent's behaviors. However, it is possible for public agencies to provide this kind of service if it is presented in a different way. Mental Health clinics, for example, could do so if the staff is willing to go into the home and work with the whole family. The large caseloads of county social service agency staffs preclude the time necessary for this type of intensive intervention; however, special units with workers carrying reduced caseloads could be established.

Confirming does not need to say or suggest that things are "all right." Rather, it is an attitude of respect, of the need to understand where the clients are in their thinking and of the importance of doing so. It can be accompanied by very clear statements of the conditions under which the two parties can work. If these include staff obligations as well as obligations of the family, they are more likely to be seen as a cooperative enterprise than of an "authority" telling the family what is expected of them. The use of systematic observations also confirms the importance of attempting to understand what is going on in the family and the staff's unwillingness to make assumptions about this. In one sense, taking the time for observations says to the family "You are important and I need to understand how you go about your life."

Providing contradiction is much of what this kind of intervention is about. The aim is to help the parent grow -- in ways that make sense to the parent -- and see new possibilities of ways of interacting with the child that meet the child's needs more appropriately and adequately, and as a result, help both feel more comfortable and happier in their relationship. In one sense, the staff listens to the small "new voice" of the parent that provides clues as to some of the ways in which the parent would like to change. The emphasis on teaching child management methods by three of the groups studied can serve this purpose particularly for parents (about a third of the total) who provide an inkling that they realize something they are doing may at least in part be contributing to the child's difficult behavior. But if the parent has problems of her own, quite apart from her parenting role, these may need attention before she can be expected to focus on her child's needs. The contradiction needs to be presented gradually - not as a criticism but as a new way of looking at and responding to the problems.

## Taking the Developmental Needs of the Parent into Account

In addition to the idea of providing a suitable holding environment in which the parents can grow and change, the developmental needs of the parent need to be considered. Using Kegan's description of the gradually developing individual, we found parents (mainly mothers as there was less information available about fathers) at three different developmental levels. Their characteristics and needs are discussed more fully in Chapter III but will be summarized here.

The imperial parent tends to be concrete in her thinking, her own needs take precedence over those of others, and it is important for her to show that she is competent. Since she is most likely referred because of difficulties in parenting, the very act of referral may be quite threatening.

A large majority of imperial mothers were rated high in "defensiveness," not surprising when one considers the difficulty staff members may have in understanding the way in which the imperial mother "makes sense" of her world. Since she is an adult, workers may assume that certain ideas and concepts are readily understood. Even when aware that some ideas do not seem to "register," they may feel it is due to their lack of skill in communication rather than the client's point of view that provides the barrier.

First of all, it is important for staff to try to understand just how the individual imperial mother views the world, what is most important to her, how she is trying to demonstrate her own competence. She may want to show that she is a capable parent, or she may find other ways quite apart from this role in which she finds satisfaction by performing well. For example, one mother, working fulltime, appeared to regard her role as a wage-earner far more important and satisfying than mothering her two children, although her husband was also employed fulltime. She spent very little time with her children, showed no affection, and could not seem to understand that her eight-year old wanted to be physically held. She needed to be confirmed as a worthwhile person before she could be expected to focus on her children's needs. In this family the father's hours meant that he was generally home when the children returned from school, and although he too was concerned with his own competence, showing it in teasing the children, for example, he was able to understand his son's desire for attention and interaction and with a little encouragement began to play with the boy. Because of many serious complications in the life of this family, intervention did not continue, but the record demonstrates the possibility of helping one parent improve the environment provided the child even if the other would need a much longer time to make a change.

Another family of two imperial parents seemed extremely unpromising. They frequently bickered and argued with each other, were absorbed in their own physical problems, and showed little attention or care for their nine-year old son who was passive and withdrawn, seeing himself as inadequate and a failure, but who at times would get into great difficulty on the school playground and be severely punished by the father. The staff not only showed interest in and concern for each family member but watched for opportunities to praise the mother to bolster her self-confidence. When they observed her making small attempts to improve her housekeeping, such as doing a few dishes out of the cluttered sink, they showered her with praise and found she responded so well to this that it became a very meaningful way of introducing contradiction or change. This had to be done in very small steps, however. Although lacking in self-confidence at first, she improved greatly in this respect, and by the end of intervention was demonstrating her competence in a variety of ways. She wanted to be a good parent, was much more positively involved with her son and felt she could stand up to her husband if he tried to abuse their son as he had done in the past.

If the idea of control is important to the imperial parent, as it is to some, care needs to be taken not just to strengthen this ability by teaching child management methods that place an emphasis on control. In one family, the mother and her two sons were in an extremely unhappy tug-of-war over power and control (with the mother locking the refrigerator so they could not "steal" food, and the boys doing destructive acts in the house). Emphasis on the importance of structure and consistency, following through on expectations with punishment if necessary, all met the mother's need for control but did not meet the sons' need for nurturance, caring, and some positive attention at the same time. Efforts to introduce these ideas were ineffective as the mother's own needs for recognition were so great that she could not attend to those of her sons. This mother had grown up in substitute care, could remember how she felt when whipped, but was unable to make the connection with how her sons might feel. She withdrew from treatment.

Although work with an imperial mother may take a long time and be difficult because of the importance of introducing contradiction so gradually that it is not unduly threatening, it can be effective. One example is with a couple referred because of the mother's great concern over her six-year old son's bursts of anger, although he was seen as compliant and quiet by the school. The staff quickly discerned -- through difficulties over scheduling and keeping appointments -- that the main problem in the family was hostility between husband and wife. The son appeared to be modeling the way he saw his parents expressing their anger. The staff worked both on teaching appropriate child management methods (to which the father responded quickly), and on counseling the parents, first exploring their relationship, what they wanted from each other, and helping them to define areas in which they would want to change. They were taught how to negotiate and compromise. Although there were complications during the course of intervention, these parents were able to change markedly. Follow-up contacts eighteen months and three years later found them enthusiastic about their own relationship and how well their children were getting along.

It is significant that the more effective work in helping imperial mothers change was done in families where there were two parents, with often the father responding more readily to the intervention than the mother. The single imperial mother is at greater risk as she is often a lonely person with no close ties to others and in great need of support and confirmation. If this can be provided, along with response to any glimmer of "another voice," which can then be supported by introducing a bit of contradiction, she can be helped gradually to grow.

The interpersonal parent is one who can recognize the needs of another and take them into account but cannot separate them fully from her own needs because of the "shared reality" with another. It is first important for the staff to understand the basis for her attachment to the "other," and to confirm the parent through attempting to understand this attachment. It could be to her child, whom she would over protect ("overhold") because of the importance to her of being "needed" by this child.

If this is the case, she may show small signs of a readiness to change a bit through recognizing that she dislikes her child's tantrumming when she gives attention to someone else. This can be the beginning of providing contradiction to her and encouraging growth, which also may make it possible for her child to grow.

A number of mothers appeared to have ambivalent relationships with their own mothers -- feeling deeply hurt by their mothers' criticisms (saying in different ways that each was a "bad mother"), but seeing a great deal of their mothers and unable to limit the contacts. In some instances, this was the primary problem rather than the child's behavior and clearly needed attention before the mother could make consistent change in the way she interacted with her child.

One mother presented a very discouraging picture when referred as a "last resort" by the county agency before they removed her two children. She had had parental rights terminated for two older children some years earlier and was very depressed, overweight, thought to be an alcoholic, and with a poor self-image at the time of referral. Her young children had been seriously neglected, and frequently got into difficulty in the neighborhood and in school. No one was optimistic about being able to help her. She appeared to be attached to her own mother who alternately criticized her severely and sought her companionship for drinking binges. The staff showed respect for her by agreeing to work with her, but were very firm in their stated expectations, particularly that there should be no evidence of the use of alcohol when they came to her home, or they would not stay. She soon learned they meant this, began responding, for example, clearing a table to work on, then next cleaning up the room in which they were to work. Praise and encouragement for these steps helped her continue. She could also see the changes in her children as she spent more time with them and set clear expectations. As she gained in self-confidence as a parent, she also was able to set some limits on her involvement with her own mother and begin to function as a more independent person. This mother improved greatly, far beyond anyone's expectations. The staff believed their willingress to go to her home and work with her (which in itself indicated their belief that the work was important), and their support of her through troublesome situations with her own mother contributed greatly to her ability to change. Although her life has not been problem-free, she has coped well with a number of difficult situations over the three years since the intervention ended. Both children are described as doing well at home and at school.

The interpersonal mother needs support in order to become independent of another person's expectations. This can be provided by staff and also by spouse or friends. In a sense, this support and encouragement is providing contradiction -- the belief that she is beginning to know what she wants to become and does not need to meet the other's expectations.

The mother (called "institutional" in Kegan's system) who has attained this state of becoming independent of another's expectations generally has a well-defined notion of self with adequate self-confidence and self-esteem. She too may be having difficulties interacting with her children or in relationship with other adults, but she is less threatened by a recognition of such problems. She needs to be confirmed by staff, that is, respected and accepted, but generally rapport is more readily established with her because the staff is likely to be at the same developmental level and, hence finds communication easier. Although mothers at this level have been found to be the most responsive to the methods of intervention studied (with extremely few rated as have made "little or no change"), it is not necessarily easy for them to change. However, even the decision to begin working on the problems may represent a greater commitment than that generally made by other mothers.

Once the individual's strengths and problems are recognized, contradiction can be introduced more quickly although it is essential that staff remain sensitive to the mother's reactions. It is important for the staff to understand the mother's ideas about parenting as she is likely to have some definite ideas of what her role is and how a child should be treated. In one instance, the mother was clearly very capable, cared for her son, but gave clues that she was not sure that she wanted to use behavioral approach. She cooperated well for a while, but when her son again began misbehaving, indicated a lack of confidence in the approach. In seems likely that time spent to find out just what her beliefs were, and then relating the suggested changes to this framework might have been helpful.

Some institutional mothers may have a problem with structure, resisting the idea that a child needs a firm structure (which varies with the child's age). This also needs to be brought out into the open so that their conflicts can be resolved; otherwise the intervention is unlikely to be effective.

It is also possible that some mothers (and fathers as well) at this level are more concerned with their careers than with their parenting, which they perceive as taking time from the other goal. Several mothers clearly had many problems reconciling the two and needed a great deal of support from the staff to confirm them in their apparently conflicting goals. Unwilling to give up on the parenting role, though, however frustrating it was, each mother in her own way gradually increased her skills as a parent and as the interaction with her children improved, she found it more rewarding and less of a primarily frustrating responsibility. These conflicts were as painful as those of a different kind experienced by imperial and interpersonal mothers; only when recognized and confirmed by staff could they be gradually resolved.

Although the kinds of intervention described in this study are very time-consuming, their costs compare favorably with the costs of substitute care for a child, either in a treatment institution or a foster home. Not all of the children described here would have required removal, but it seems likely that a large majority would at some time. Further, the emotional and psychological costs to a family produced by the removal of a child cannot be estimated. When intervention involves the entire family, as was the case in these four agencies, it not only helps the identified child but the parents, in their own relationship as well as in their ability to parent all of their children. It can be regarded as a worthwhile investment in the future.

# REFERENCES

Bowen, M. Family Therapy in Clinical Practice. New York: Jason Aronson, 1978.

Becker, W.C. Parents Are Teachers. Champaign, Ill.: Research Press, 1976.

Butcher, J.N. and Koss, M.P. Research on brief and crisis-oriented therapies. In S.L. Garfield and A.E. Bergin (Eds.) Handbook of Psychotherapy and Behavior Change. New York: Wiley, 1978, 725-767.

Callard, E.D. and Morin, P.E. (Eds.) Parents and Children Together: An Alternative to Foster Care. Detroit: Department of Family and Consumer Resources, Wayne State University, 1979.

Camp, B. W. A Pilot Study of Verbal Learning in Young Aggressive Boys. ("Think Aloud" Program ED 142 024) Arlington, Va.: ERIC. Now published by Research Press in Champaign, Ill., 1981.

Cautley, P.W. Treating dysfunctional families at home. Social Work, 1980a, 25, 380-386.

Cautley, P.W. Family stress and the effectiveness of in-home intervention. Family Relations, 1980b, 29, 575-583.

Cautley, P.W. Facilitating Long-term Optimal Planning for Children (Project OPT). Madison, Wis.: Wisconsin Department of Health and Social Services, 1979.

Cohn, S.H. Effective treatment of child abuse and neglect. Social Work, 1979, 24, 513-519.

Fahl, M.A. and Morrissey, D. The Mendota model: Home-community treatment. In S. Maybanks and M. Bryce (Eds.) Home-based Services for Children and Families: Policy, Practice and Research. Springfield, Ill.: Charles C. Thomas, 1979, 225-236.

Fahl, M.A. Shaping parent-child interaction: A behavioral model in a family context. In M.E. Bryce and J.C. Lloyd (Eds.) Treating Families in the Home: An Alternative to Placement. Springfield, Ill.: Charles C. Thomas, 1980, 165-179.

Fanshel, D. and Shinn, E.B. Children in Foster Care: A Longitudinal Investigation. New York: Columbia University Press, 1978.

Gurman, A.S. and Kniskern, D.P. Family therapy outcome research: Knowns and unknowns. In A.S. Gurman and D.P. Kniskern (Eds.) Handbook of Family Therapy. New York: Brunner/Mazel, 1981, 742-775.

Haapala, D. and Kinney, J. Homebuilders' approach to the training of in-home therapists. In S. Maybanks and M. Bryce (Eds.) Home-based Services for Children and Families. Springfield, Ill.: Charles C. Thomas, 1979, 248-259.

Hubbell, R. *Foster Care and Families: Conflicting Values and Policies.* Philadelphia, Penna.: Temple University Press, 1981.

Hull, C.H. and Nie, N. SPSS Update 7-9 New Procedures and Facilities for Release 7-9. New York: McGraw-Hill, 1981.

*Issues and Experiences in Permanent Planning*. Portland, Ore.: Regional Research Institute for Human Services, Portland State University, 1980.

Jones, M.S., Magura, S. and Shyne, A.W. Effective practice with families in protective and preventive services: What works? *Child Welfare*, 1981, *60*, 67-80.

Jones, M.A., Neuman, R. and Shyne, A.W. *A Second Chance for Families: Evaluation of a Program to Reduce Foster Care*. New York: Research Center, Child Welfare League of America, 1976.

Kadushin, A. *Child Welfare Services.* New York: Macmillan, 1980.

Kegan, R.G. The evolving self: A process conception for ego psychology. *The Counseling Psychologist*, 1979, *8*, 5-34.

Kegan, R.G. *The Evolving Self*. Cambridge, Mass.: Harvard University Press, 1982.

Kinney, J., Madsen, B., Fleming, T. and Haapala, D. Homebuilders: Keeping families together. *Journal of Consulting and Clinical Psychology*, 1977, *45*, 667-673.

Kohlberg, L. The concepts of developmental psychology as the central guide to education. In M.C. Reynolds (Ed.) *Psychology and the Process of Schooling in the Next Decade*. Minneapolis: Department of Audio-Visual Extension, University of Minnesota, 1972, 1-55.

Lebow, J. Issues in the assessment of outcome in family therapy. *Family Process*, 1981, *20*, 167-188.

Magura, S. and Moses, B.S. Outcome measurement in child welfare, *Child Welfare*, 1980, *59*, 595-606.

Nie, N.H., Hull, C.H., Jenkins, J.G., Steinbrenner, K. and Bent, D. *SPSS Statistical Package for the Social Sciences*, Second Edition. New York: McGraw-Hill, 1975.

Piaget, J. Piaget's theory. In P.H. Mussen (Ed.) *Carmichael's Manual of Child Psychology*. New York: Wiley, 1970.

Pike, V. Permanent planning for foster children: The Oregon Project. *Children Today*, 5, 1976 (November-December), 22-25, 41.

Patterson, G.R. *Living with Children*. Champaign, Ill.: Research Press, 1976.

Ryan, M. Families' program design: Giving families relevance in treatment. In S. Maybanks and M. Bryce (Eds.) *Home-based Services for Children and Families: Policy, Practice and Research*. Springfield, Ill.: Charles C. Thomas, 1979, 272-282.

Shyne, S.W. and Schroeder, A.G. *National Study of Social Services to Children and Their Families*. Rockville, Md.: Westat, Inc., 1978.

Stein, T.J. and Gambrill, E.D. Behavioral techniques in foster care. *Social Work*, 1976, *21*, 34-39.

Tharp, R.G. and Wetzel, R.J. *Behavior Modification in the Natural Environment.* New York: Academic Press, 1969.

*The Home and Community Treatment Process: Helping Families Change*. Madison, Wis.: Mendota Mental Health Institute, 1979.

Woodward, C.A., Santa-Barbara, J., Streiner, D., Goodman, J.T.,Levin, S. and Epstein, N.B. Client, treatment, and therapist variables related to outcome in brief, systems-oriented family therapy. *Family Process*, 1981, *20*, 189=197.

# APPENDIX

## FAMILY RATING SCALE

Family #____________ Rater __________________________ Date ____________

A. Life maintenance or physical nurturance.
Extent to which the family has (provides) enough food, clothing, shelter and hygiene or health care to sustain life at a healthy level.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Severely deficient in 3 or 4 areas | Severely deficient in 1 or 2 areas | Deficient in one or more areas | Slightly deficient in one or more areas | Not deficient in provision of these needs (Continuously provides) |

In the following items, rate each child separately if there appear to be marked differences in the ways the children are treated. Rate each parent separately if necessary.

B. Emotional nurturance of the children by the parents.
Extent to which the parents have warm positive interaction with each child and demonstrates recognition of the child's separateness and worth (individuality).

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| No evidence of nurturance | Minimal level | Somewhat less than adequate | Adequate | High level of nurturance |

## FAMILY RATING SCALE
Page 2

C. Cognitive development of children.

Extent to which a positive and stimulating environment is provided by the family for the children.

| | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

D. Socialization of children.

Extent to which an environment is provided for socializing the children at appropriate level for age and development.

| | | | |
|---|---|---|---|
| 1 | 2 | 3 | 4 |
| No evidence of such an environment | An environment far less than adequate | An environment somewhat less than adequate | An adequate environment |

Note: If adult(s) other than parents, rate each separately.

E. Adults

Extent to which adults in the family support each other emotionally. (Rate all adults, two at a time.)

| | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | Slight extent | Fair extent | Considerable extent | Great extent |

## DESCRIPTION OF FAMILY RATING SCALE

The following scales are described briefly on the rating form but the following criteria are useful in thinking about the various distinctions made. A rating may actually be checked at any point on the line and does not have to coincide with one particular number.

A. Life maintenance or physical nurturance.

   5. Not deficient in provision of these needs (continuously provides). Clean house and clean adequate clothes are provided, as well as adequate food and appropriate medical care. Parent is alert to health needs of child, including adequate rest, outdoor play, importance of immunization, etc.
   4. Slightly deficient in one or more areas. House is not clean, dishes not done, but clothing is good and food is adequate. May not have regular medical check-ups but parent is reasonably alert to health needs of child.
   3. Deficient in one or more areas. House is disarray, many dirty dishes piled in sink.
   2. Severely deficient in one or two areas. Housing very inadequate (serious unsanitary conditions); no regular meals served and older child permitted to get own food whenever he wishes it. Parent ignores illness until extreme (only deficiency noted).
   1. Severely deficient in three or four areas. House filthy; children wear dirty clothes to school and are reported to having unpleasant odor; food inadequate or inappropriate much of the time.

B. Emotional nurturance of the child(ren) by the parents, defined as the extent to which the parents have warm positive interaction with each child and demonstrate recognition of the child's separateness and worth (individuality).

   5. High level of nurturance, but at same time parent recognizes child's separateness and need for growth; shows spontaneous expression of affection and acceptance.
   4. Adequate. Warm with child, but does not always respond to child's show of affection or desire for it.
   3. Somewhat less than adequate May have warm interaction but fails to recognize child's separateness ("smothers child"). May be so puzzled or frustrated by child that he/she fails to show much warmth or may be wrapped up in own complaints and fails to show much warmth or acceptance towards child, or shows warmth with reservations.
   2. Minimal level. Unpredictable affection; inconsistent in expression of warmth.
   1. No evidence of nurturance. Does not respond to child's show of affection or desire for it, or may reject child in many ways, or shows clear dislike for child.

C. Cognitive development of child(ren), defined as the extent to which a positive and stimulating environment is provided by the family for the child(ren).

5. Good extent.
   Provides age appropriate experiences, toys, activities, games, some with adults; carries on conversation with child.
4. Considerable extent.
   Considerable in at least three of the four areas listed under score 5. Responds to child's initiation of questions or interests.
3. Fair extent.
   Provides some of at least three of the different types mentioned under score 5.
2. Slight extent.
   Provides considerable stimulation in only one of the areas listed, or only some in two of them, or slight in three.
1. Not at all.
   Very few or no appropriate toys or interaction with child; mainly ignores child or gives primarily negative commands to child.

D. Socialization of child(ren), defined as the extent to which an environment is provided for socializing the child at appropriate level for age and development.

4. An adequate environment.
   Parent makes clear expectations regarding appropriate social interaction; teaches child how to get along with others; teaches child to take care of self in daily living at level appropriate for age.
3. An environment somewhat less than adequate.
   Makes some attempt to socialize child but is lacking in specific ways, e.g., may teach child to take care of self but pays relatively little attention to teaching child how to get along with others.
2. An environment far less than adequate.
   Makes only slight attempt to socialize child or teach ADL, or make generally inconsistent attempts, or parent is dominated by child and gives in to child's demands.
1. No evidence of such an environment or of parents attempts to socialize child in regard to either interaction with others or taking care of self in daily living.

Table 1

Correlations of Parent Change Score and Child Change Score with Independent Variables for Families Served by Four Agencies and by Three (HCT, FTP, and OPT)

| | Correlations with | | | |
|---|---|---|---|---|
| | Parent Change Score | | Child Change Score | |
| Characteristics of families and child: | Total | HCT,FTP OPT | Total | HCT, FTP, OPT |
| Mother's educational level | .264* | .336* | .179+ | .257* |
| One or two-parent family | .044 | .102 | .114 | .120 |
| Reason for referral | .061 | .062 | .008 | .193+ |
| Prior treatment | .016 | .010 | .027 | .036 |
| Problems of family mainly child, adult, or both | .328* | .334* | .308* | .363* |
| Degree of difficulty of child | .137+ | .158+ | .219* | .234* |
| Child with handicap | .020 | .114 | .022 | .084 |
| Mother's background | --- | .312* | --- | .241* |
| Parents' relationship | .430* | .412* | .269* | .315* |
| Mother's developmental level | --- | 553* | --- | .439* |
| Goals of intervention for parents | | | | |
| Teach child management methods | .165+ | .207+ | .181+ | .186+ |
| Didactic training | .226+ | .284* | .236* | .230+ |
| Resolve parent problems | .071 | .141 | .127 | .148 |
| Improve interaction with child | .068 | .043 | .059 | .002 |
| Improve relationship with spouse | .003 | .059 | .038 | .088 |
| Adult problems of parents | | | | |
| Problems with spouse | .067 | .013 | .246* | .101 |
| Problems with adults other than spouse | .253* | .216* | .253* | .227* |
| Immaturity | .173+ | .243* | .182+ | .165+ |
| Total number of adult problems | .219* | .265* | .178+ | .176+ |
| Problems in interaction with child | | | | |
| Negative interaction with child | .057 | .030 | .110 | .073 |
| Lacks understanding of child's abilities and training potential | .058 | .035 | .174+ | .163+ |
| None other than need to learn child management methods | .165+ | .185+ | .134 | .150 |
| Parent's attitude during intervention | | | | |
| Parent's defensiveness | .634* | .667* | .460* | .533* |

* p = .01 or better

+ p = between .01 and .05